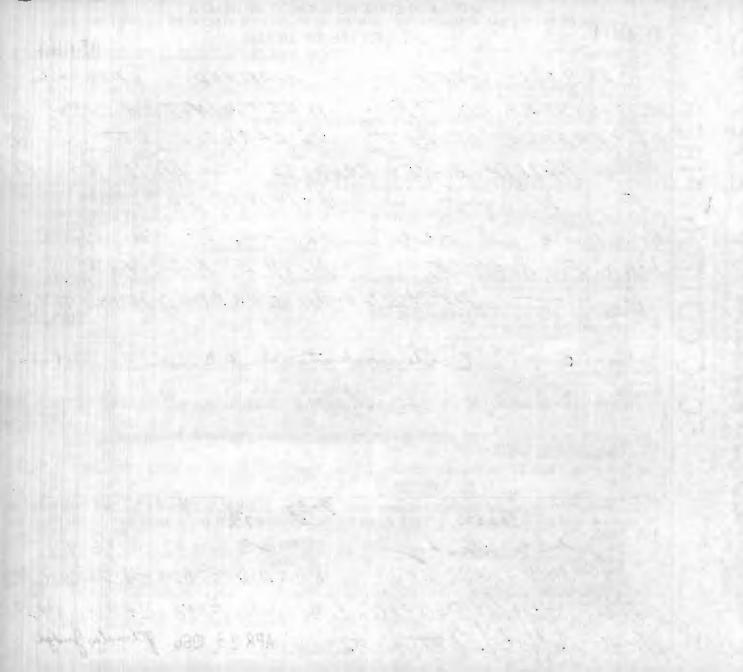
ARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence a. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 1b OR TOWN (If outside corporate limits, write RURAL end give nearest town) write RURAL and give nearest town) d. NAME OF HOSPITAL OR d. STREET ADDRESS INSTITUTION (if not In hospital, give street address) a. IS RESIDENCE ON A FARM? OUT YES NO . 3. NAME OF First Middle DATE Month DECEASED (Type or print) DEATH 19 COD and cor AGE (In years | IF UNDER I YEAR | IF UNDER 24 HRS 7. MARRIED NEVER MARRIED last birthday) WIDOWED [DIVORCED USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY done during most of working life, even if retired) FARM FATHER'S NAME GERTRUDE CONSTANTINI WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) [(If yes give war or dates of service 18. CAUSE OF DEATH |Enter only one cause per line for (e), (b), end INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (+) **DUE TO** Conditions, if eny, which (b) gave rise to immediate cause DUE TO (a), stelling the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO [20a. ACCIDENT WAS UNDERLYING T 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING | CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED ! 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (Stete) fectory, street, office bldg., etc.) While Not While Hour a.m. at work at work 21. I certify that (I) (this hospital) attended the deceased from 17.1 saw the deceased alive on 22b. DATE ATTENDING PHYS. DIRECTOR PHYS. HOSPITA ADDRESS 22d. 23d. LOCATION (City, town or county) (Stete) DATE THEREON CREMATORY ÷ 0 25a. REC'D BY REGISTRAR 25b. REGISTRAN 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) 15M 7/61

LETTER FOR SECURIO 14 FEBRE TRUCKS FOR THE PROPERTY OF THE PRO 1年 ヨマレンロ 4 3 7 A TECHNOSE COR PRINCIPLE PRINCIPLE LE NECESTRATES PIPLE WHITE 27 3PS 1 3131 AT = 100 TO FATINER THRAINS SHIP OF THE SHIP HAMMET LILLINGS SERTRUDE CONSTRUCTS JUHN THURE 一点上、不是是我们是我们是我们是我们的 THE CHECK WORLD SE PRINCESSES TERMS ENDINES I VERLLIGHT IN KINGE ROT WESTIMMENED BY A STATE OF THE STA A STATE OF THE STA

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 after death, and 2 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY a. STATE b. COUNTY by the fa CAR MARYLANO CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) hours hours .= bon papers. within 72 ho d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled i d. STREET AOORESS e. IS RESIDENCE ON A FARM? 24 NOX YES an and completely fe remove carbon point in any event, within within 3. NAME OF First Middle DATE Month Oav 1 ast Year DECEASED (Type or print) DEATH 19 executed 5 SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS last birthday) Months | Days | Hours | Min. 9. 7. MARRIED NEVER MARRIEO WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done physician n please r 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT þ during most of working life, even if retired) INDUSTRY COUNTRYZ 0 death certificate FATHER'S NAME MOTHER'S MAIDEN NAME attending ph removal 15. WAS DECEASED EVER IN U.S. ARMED FORCES! 16. SOCIAL SECURITY NO. INFORMANT 17. permit. 10 (Yes, no, or unkown) (If yes give war or dates of service) cremation, the s been signed by and s the burial-transit p ior to burial, cremati CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician. IMMEDIATE CAUSE (a) **OUE TO** illusosslustic Heart N. Conditions, If any, which gave rise to immediate OUE TO cause (a), stating the prior underlying cause last. TO FUNERAL DIRECTOR: After this certificate has director, page 3 should be detached for use as should be filed with the State Dept. of Health prior (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY 19. PERFORMEO? CERTIFICAT YES (N∙O 20a. ACCIDENT WAS UNDERLYING T DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part | or Part |) of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While p.m at work at work 21. I certify that (I) (this hospital) attended the deceased from 196 saw the deceased alive on and that death occurred at. from the causes and on the date stated above. 22a. SIGNATURE 22b. OATE SIGNED ATTENOING MEO. DIRECTOR PHYSICIAN'S 22d. ADDRESS 22c. director, p NAME (Type) BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) 23d. REMOVAL (Specify) 13 FUNERAL OIRECTOR ADDRESS REC'O BY REGISTRAR 25b. REGISTRAR'S VR AI5 (4) 20M 1/65

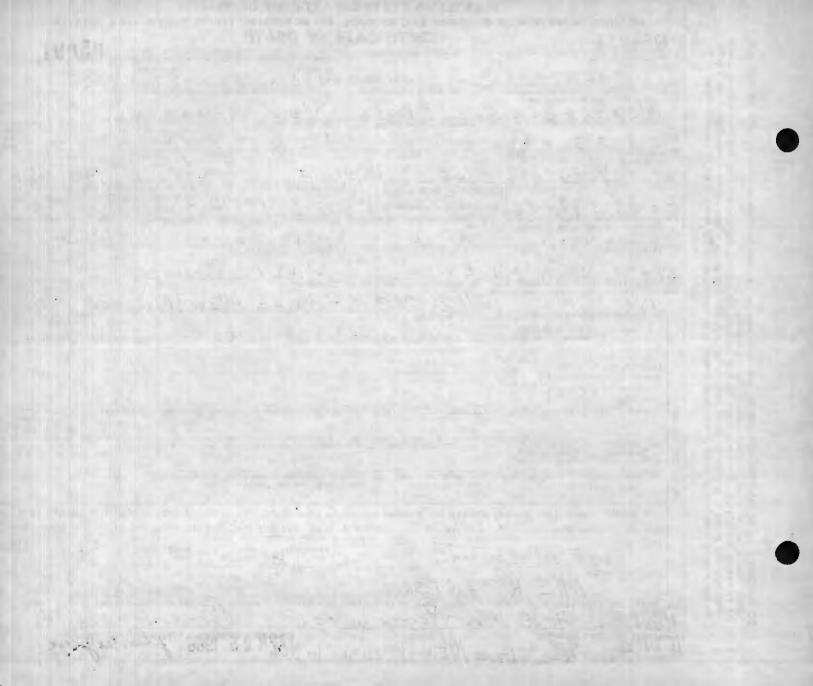


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-	b. CITY OR TOWN	(if outside corporate limited give nearest lown)			c. CITY OR TOW	Y (If outside co	rporate limits, wri	Carro	11 give neares	town)
-	Union Br:	idge RD #1	50 yrs f not in hospital, give street address)	Union Br.	~	D #1		04-	S RESIDENC
0 =	. NAME OF		•				Y			NO NO
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	. sex female	6. COLOR OR RACE	7. MARRIED X NEVER MARRIED WIDOWED DIVORCED	8.	DATE OF BIRTH	36	9. AGE (In years last birthday)	IF UNDER 1 Y		DER 24 HRS
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1	. FATHER'S NAME	поизен	TT C	1	Carroll (aryland	0.5	.A.	F1 1 7 9 4 1 1 1 1
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Ç	(es, no, or unkown)	VER IN U.S. ARMED FOR (Ifyasgivewarordatesofsa	CES? 16. SOCIAL SECURITY NO.		h H. Baby	lon	Addres			
	PART I. DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (+) DUE TO y, which \(\) (b)	Care	no	ma -	si	Smail	d.	INTERVAL ONSET	BETWEEN NO DEATH
7	gava risa lo imma (a), stating the causa last.	undarlying DUE TO	IONS CONTRIBUTING TO DEATH E						(a): 19. W/	S AUTOPS
CERTIFICATION		VAS UNDERLYING G CAUSE OF DEATH Y MEDICAL EXAMINER)	206. DESCRIBE HOW INJURY OC							RFORMED?
MEDICAL C		1	r 20d. INURY OCCURRED 20 Whila Not Whila at work at work	e. PLA (facto	CE OF INJURY (Homa, force), straat, office bldg., i	arm, 20f. (C	ity or town)	(Count	νl	(State)
	saw the decea	that (I) (this hospitalised alive on4.	al) attended the deceased		death occurred at a	9 19 to	m the causes	1.66 19 and on the	date sta	l) (ws) Ta
	22e. SIGNATURE		tran	LM	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS,		4/4	22b. DATE SIGNI
	NAME (Type				220. ADDRESS	Neu	Wi	ndre	~,	md
2:	REMOVAL (Specify Durial	100N, 23b. DATE THER	Baust Chur		Eeme to py	Uni	on Brid	ge RD1	Md.	(State)
24	EUNERAL DIRECTO	R'S SIGNATURE	ADDRESS ADDRESS		250. I		STRAR 25b. RE	GISTRAR'S SI	SNATURE	
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MAKTLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND DEATH Selection PLACE OF DEATH 2. USUAL RESIDENCE (Whara decreased lived, if institution: within 24 hours a. COUNTY by the and 2 death. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits. à c. LENGTH OF STAY IN 16 write RURAL end give neerest town __ Pages filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) hours STREET ADDRESS . IS RESIDENCE ON A FARM? completely YES NO DE 72 3. NAME OF DATE Month Dev Year DECEASED OF (Type or print) DEATH 19 carbon withi SEX AGE (In yeers | IF UNDER 1 YEAR F UNDER 24 HRS pue 7. MARRIED NEVER MARRIED birthdey) Months Days Hours certificate WIDOWED X DIVORCED cian 10e, USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME MOTHER'S MAIDEN NAME death ā EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, nos orjunkown) | (Ifyesgive yer ordetes of service) CAUSE OF DEATH [Enter only one cause per line for INTERVAL BETWEEN ö ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e 222 **DUE TO** Conditions, if any, which geve rise to immediate cause DUE TO (e), steting the underlying cause lest. (c) \$ p PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19, WAS AUTOPSY CERTIFICATION PERFORMED? 950 prior NO [YES 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter neture of injury in Pert I or Pert II of item 18.) Health (IF EITHER, NOTIFY MEDICAL EXAMINER) detached 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED I 20e, PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) (Stete) o, fectory, street, office bldg., etc.) While Not While Hour a.m. DIRECTOR: at work at work p.m. 1. H. 6 19 that (1) (wo) last 21. I certify that (I) (this hospital) attended the deceased from..... 10/1/4.19......, and that death occurred at // 15/1, from the causes and on the date stated above. saw the deceased alive on...... 22e. SIGNATURE DATE ATTENDING MED. STAFF SIGNED eth. Page 4 page with # HOSPITAI DIRECTOR PHYS. M.D. 22d. ADDRESS 22c. PHYSICIAN'S filed v NAME (Type) DATE THEREO! CEMETERY OR CREMATORY 23d. LOCATION (City, town or county (Stete) BURIAL, CREMATION. 23a. 中岛 0 0 FUNERAL DIRECTOR'S SIGNATURE **VR A1S (4)** 20M 5-63





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the haspital or attending physician.



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	05094			CERTIFIC	CATE	OF DEATH				1)5	092	2
	1. PLACE OF DEATH o. COUNTY Carrol	1		MARYLA	ND	2. USUAL RESIDENCE (V o. STATE Maryland			on Residen			on)
	Sykesyi	If autside carparate limit d give nearest tawn)		e LENGTH OF STAY IN 9 days	lb	c. CITY OR TOWN (If ou Baltimor				re neares	t town)	
2		al or institution (if no eld State 1				d. STREET ADDRESS 2926 Har	ford Ro	ad			B. IS RESIL ON A FA YES	DENCE ARM? NO .
	3. NAME OF DECEASED (Type or print)		SSELL	Middle RODNEY		BARBE	4. DATE OF DEATH	Month APRI		Doy	Yei 19	66
	S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED		9-15-1892	73	GE (In years ust birthday) yrs.	IF UNDER Months		Hours	Min.
	10a, USUAL OCCUPATION during most of working Unik.	(Give kind of work done life, even if retired)		ND OF BUSINESS OR IDUSTRY		11. BIRTHPLACE (County Virginia	& State, or foreig	n country)	(0	TIZEN OF DUNTRY?		
	13. FATHER'S NAME A. Frank	Barbe	1			14. MOTHER'S MAIDEN I		odt				
		R IN U.S. ARMED FORCES? (If yes give war or dates (Unk.	of service)	SOCIAL SECURITY NO. Unk.	100	nformant cords, Spri	ngfield	Addre State		ital		
	PART I. DEA	EATH (Enter only one cou TH WAS CAUSED BY: IMMEDIATE CAUSE	(a) Bi	(o), (b), ond (c).) lateral bro	nche	pneumonia				ON	ERVAL BET SET AND D	
	Conditions, if ony	, which gave)	(b) Ar	teriosclero	tic	heart disea	ise			y	rears	

	IMMEDIATE CAUSE	a) Bilateral bronchopneumonia	days
	Conditions, if ony, which gave inse to immediate cause (a),	Arteriosclerotic heart disease	years
	stating the underlying couse last.	(c)	
CATION	PART II. OTHER SIGNIFICANT CONDITIONS CO. Diabetes	INTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)	19. WAS AUTOPSY PERFORMED? YES NO
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MEDICAL	20c. TIME OF INJURY Month, Day, Year Haur o.m.	20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, While Not While factory, street, affice bldg., etc.)	(County) (State)

M.D.

CEMETERY OR CREMATORY

20c. TIME OF INJURY Month, Day, Year Haur o.m.

at work

and that death accurred at

to 1-23-66, 19, that (I) (we) last my fram causes and an the date stated abave.

21. I certify that (I) (this haspital) attended the deceased fram saw the deceased glive an 4-23-66 19 , and the saw the deceased alive an

220. SIGNATURE

23b. DATE THEREOF

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

226. DATE SIGNED 4-25-66

22d. ADDRESSSpringfield State Hospital Sykesville, Maryland 22c PHYSICIAN NAME (Type Octavio A. Ruiz, M. D.

23q

BURIAL, CREMATION, REMOVAL (Specify) FUNERAL DIRECTOR

ADDRESS

250. AFCID BY REGISTRAY 966

LOCATION (City or Town)

(State) (County)

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please regione corbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in day went, within 72 hours after death.

director, page 3 should be detached for use os the burial-transit permit. Then please reshove can should be filed with the State Dept. of Health prior to burial, cremation, ar removal, and in dny arealt,

VR A15 (4) 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 05095 funeral 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before edmission 1. PLACE OF DEATH a. COUNTY **b.** COUNTY Carroll MARYLAND Marvland b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If outside corporete limits, write RURAL and give neerest town) write RURAL and give nearest town) Finksburg Finksburg 20 years d. STREET ADDRESS IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, a ve street address) ON A FARM? School House Lane School House Lane YES NO TK 3. NAME OF A. DATE Middle OF DECEASED (Type or print) DEATH Albert Bean 19 66 Apri. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED TO 9. AGE (In years | IF UNDER I YEAR IF UNDER 24 HRS. 8. DATE OF BIRTH last birthday) Months Male WIDOWED DIVORCED T 10a. USUAL OCCUPATION IGive kind of work 12. CITIZEN OF WHAT COUNTRY! 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHP, ACE (County & State, or foreign country) done during most of working life, even if retired Carroll Co., Md. Laborer 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Savilla Warfield George T. Bean 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (Hyesgive wer or dates of service) Finksburg, Md. Mrs. Earl F. Mann No None INTERVAL BETWEEN 18. CAUSE OF DEATH Enter only one cause per line for (e), (b), end (c), ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Bronchial Pneumonia hrs IMMEDIATE CAUSE (a) DUF TO Conditions, if any, which geve rise to immediate cause DUE TO (a), steting the underlying Arteriosclerotic C.V. Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) 19. WAS AUTOPSY PERFORMED? NO X Gastric ulcor 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of in ury in Part I or Part II of item 18.) 20s. ACCIDENT WAS UNDERLYING [] 1 OR CONTRIBUTING CAUSE OF DEATH (Stelle) 20c. TIME OF INJURY Month, Day, Yeer 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) lectory, street, office bldg., etc.) Not While Hour e.m. et work at work 21. I certify that (I) (this hospital) attended the deceased from Sept. 28. 19.50 to April 22, 19. 6(that (I) (we) last saw the deceased alive onApril 20.19.66, and that death occurred at PPM, from the causes and on the date stated above. 22b. DATE 22a SIGNATURE SIGNED ATTENDING DIRECTOR PHYS. M.D. 22d. ADDRESS 22r. PHYSICIAN'S NAME (Type Main St. Reisterstow, 23d. LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY (State) 23a. BURIAL, CREMATION, | 23b. DATE THEREOF REMOVAL (Specify) Reisterstown, Md. Deer Park Methodist Cem. 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 15M 7-62

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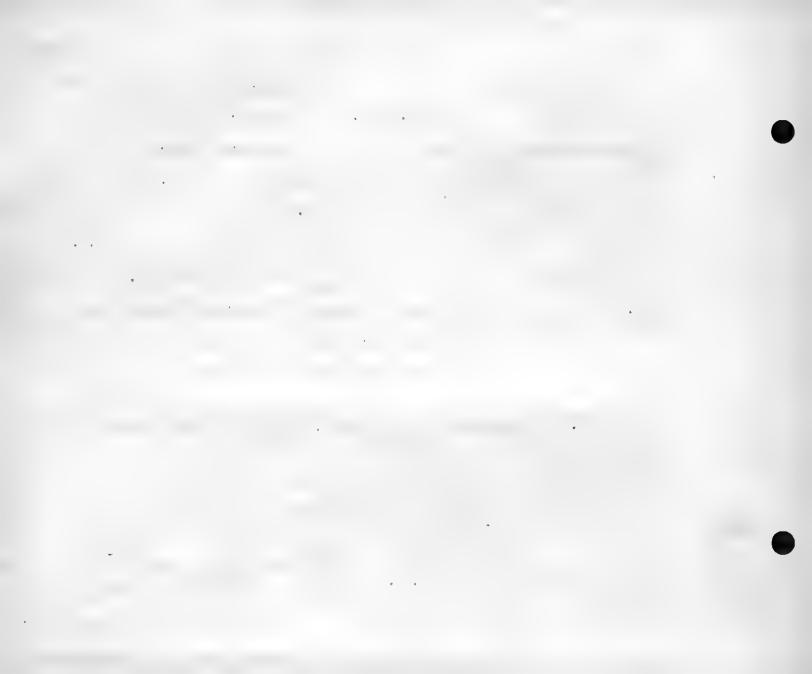
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05096 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o COUNTY Carroll Marvland MARYIAND b City DR TDWN (If outside corporate limits, write RURAL and give nearest tawe)
Rural -- Sykesville c. LENGTH DE STAY IN 16 c. CITY DR TDWN (If autside corporate limits, write RURAL and give negrest town) days Strestille 151 W. All Saints St. e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS filled Frederick Springfield State Hospital YES 🗍 ND 🔀 3 NAME OF Middle Lost 4 DATE First Month Day Year DECEASED Bentley Carrie Amelia April 30 10166 (Type or print) DEATH S SEX 6. CO.OR OR RACE B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED **NEVER MARRIED** and in any ev 86 birthday) Dovs Haurs Mar. 25,1880 female Negro WIDOWED DIVORCED 12 CITIZEN OF WHAT 10g USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or fareign country) during most of working life, even if retired) COUNTRY? INDUSTRY Maryland 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME buriol, cremation, or removal, James Bentley Susan Skinner WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY ND. (Yes, no, or unknown) (If yes give wor or dotes of service) Springfield Hompital Records, Sykesvill INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the buriol-transit p PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO RICTIC HEART DISEX Conditions, if ony, which gove rise to immediate cause (a), DUE TO stating the underlying cause this certificate has been for use as the WAS AUTOPS PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES 🔀 20g ACCIDENT WAS UNDERLYING □ 205, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 of Part 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) TIME OF INJURY Month, Dov. Year factory, street, affice bldg., etc.) Not While 19 O FUNERAL DIRECTOR: After 21. I certify that M (this haspital) attended the deceased fram 4-22-, 1966, to 130/6019, that M (we) tast saw the deceased alive an 4-30-1966, and that death accurred at 13960, M, fram causes and an the date stated above. director, page 3 should should be filed with the 22n. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. DIRECTOR Springfield State Haspita 22d. ADDRESS 22c. PHYSICIAN S NAME (Type) 23o. BURIAL, CREMATION 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City of Town) (County) (Stote) REMOVAL (Specify)
Burial Frederick, Md 5/3/66 Frederick Fairview 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (41/ Hicks



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05097 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. death. the attending physician and completely filled in by the funeral sit permit. Then please remove carbon papers. Pages I and notion, or removal, and in an leven within 72 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Barroll Maryland Washington MARYLAND b CITY OR TOWN (If outside corporate limits, c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 Rural -- Sykesville 5m. 4d. Smithsburg d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? Springfield State Hospital NO 3 NAME OF Middle Lost 4 DATE Month Doy Year DECEASED 4 19 66 Roberta ? Bishop 11 (Type or print) DEATH SEX 8 DATE OF BIRTH IF UNDER 24 HRS. 6 COLOR OR RACE 7 MARRIED 9 AGE (in years IF UNDER 1 YEAR NEVER MARRIED birthdoy) Dovs Hours 12/11/87 female white WIDOWED DIVORCED cremotion, or removal, and in an 100 USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? USA Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER S NAME Alice Besare John Bishop IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECHRITY NO 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) Springfield Hospital records-Sykesville no none INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) signed by the buriol-tronsit p buriol, cremotic PART I DEATH WAS CAUSED BY ONSET AND DEATH Chronic congestive heart failure IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gove Mitral calcification and stenosis rise to immediate couse (a). DHE TO stoting the underlying couse Page 4 may be retained by the certificate has been to FUNERAL DIRECTOR: After this certificate has been as the Page 4 may be retained by the hospitol or ottending prior to Chronic rheumatic heart disease lost PART IS OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? CALON detached for use Schizophrenic reaction, paranoid type. Gen. Arteriosclerosis YES X NO F 20b, DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item 18) 20o ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 3 should be detached with the Stote Dept. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Year (County) foctory, street, office bldg., etc.) **Not While** of work ot work 1900 , that (1) (we) last 21. I certify that (F (this hospital) attended the deceased from. 19.27 to. 19 66, and that death occurred at 10:40, from causes and on the date stated above 4/11/ saw the deceased alive on 22o. SIGNATURE 22b. DATE SIGNED ATTENDING MED. DIRECTOR STAFF PHYS 4/11/66 Heen 区 director, page 3 should be filed v M.D. PHYS Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S Edmee J. Reeves. M. D. NAME (Type) Sykesville. Maryland 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a BURIAL, CREMATION, 23b. DATE THEREO! (County) (Stote) REMOVAL (Specify) SMITHSDURG WASH MITHSBURG 2So REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Milantes VR A15 (4) 20 M 1/66



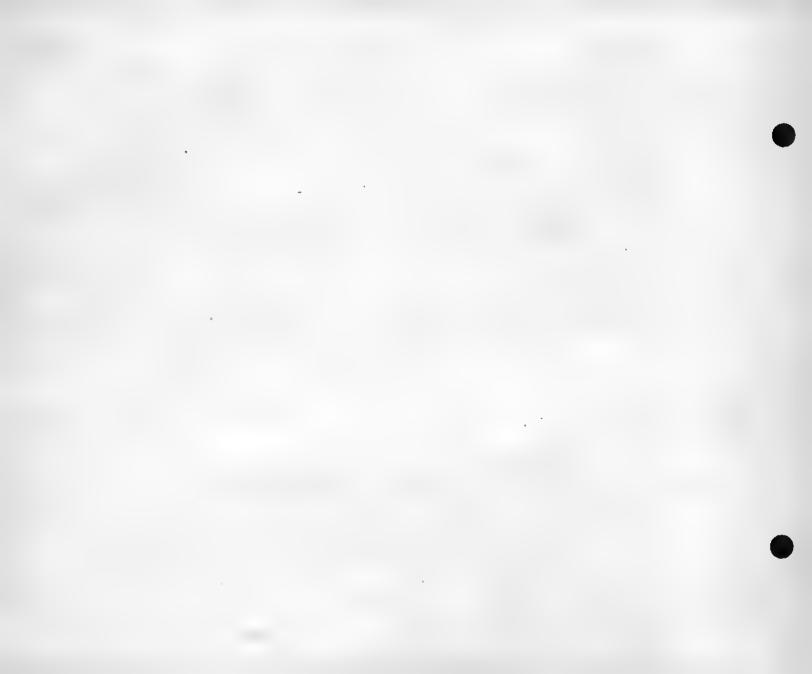
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05099 CERTIFICATE OF DEATH death, The law requires that the death certificate be executed within 24 haurs after death and completely filled in by the funeral remove carban papers Pages I and in any event, within 72 haurs after death 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o. COUNTY a. STATE b. COUNTY Carroll MARYLAND Maryland Montgorn
c CITY OR TOWN (If auts de carparate limits, write RURAL and give neares) tawn) Montgomery b CITY OR TOWN (if autside carparate limits, r JENGTH OF STAY IN 16 write RURAL and give negrest town) 6mo 18da Silver Spring Sykesville
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? d STREET ADDRESS and in any event, within 72 1312 Dennis Ave. YES NO Springfield State Hospital 3 NAME OF 4. DATE Lost Month Day Year DECEASED April 1966 16-(Type or print) James DEATH Meredith IF UNDER 24 HRS. IF UNDER X SEX 6 COLOR OR RACE 9 AGE (In years 7. MARRIED NEVER MARRIED last birthday) Manths Days Hours Male White WIDOWED DIVORCED 2-27-78 10a USUA, OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Virginia U.SA. Farmer the attending plysicilities of sit neemst 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME remova Not Known Catherine AddressSykesville 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes no grunknown) (If yes give war or dates of service) P Maryland Springfield Hosp, Records No 223-03-6053 crematian, 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY

Arteriosclerotic Cardio vascular disease INTERVAL BETWEEN signed by the burial-transit p burial, crematic ONSET AND DEATH IMMEDIATE CAUSE (o) Beginning gangrene DUE TO Weeks Conditions, if any, which gove rise to immediate cause (a), DUE TO Advanced Generalized Arteriosclerosis Page 4 may be retained by the haspital ar attending IO FUNERAL DIRECTOR: After this certificate has been a director, page 3 should be detached far use as the I should be filed with the State Dept af Health priar ta Is stating the underlying couse last Years WAS AUTOPSY PERFORMED? PART II DITHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO S Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis YES 200 ACCIDENT WAS UNDERLYING [205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (Stote) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (County) Hour o.m. Not While factory, street, office blda., etc.) at wark 10-28-63, 19 to 1, 76-66, 19_, that (I) (we) last 21 I certify that (I) (this haspital) attended the deceased fram_ and that death accurred at 8:45AM, from causes and on the date stated above saw the deceased alive on. 92a SIGNATIVE 22b. DATE SIGNED ATTENDING MED DIRECTOR STAFF PHYS 4-16-66 22d_ADDRESS PHYSICIAN'S Antonius Glahn, Md Sykesville, Maryland NAME (Type) 23d, LOCATION (City or Town) 230 BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (State) REMOVAL (Specify) ex119exington eme tery ADDRESS. 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



1	1	MARYL	AND STATE DEP	ARTMENT OF	HEALTH	
		DIVISION OF STATISTICAL RESEARCE			STREET, BALTIMO	RE 1, MARYLAND
]	05100	CERTIFICATE	OF DEATH		05000
ž	/ ₹	PLACE OF DEATH a. COUNTY			CE (Where deceased lived, I	
		CARROLL	MARYLAND	a. STATE MA	RYLAND 6. COL	INTY CARROLL
		b. CITY OR TOWN (if outside corporata limits, write RURAL and give necrest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (lf oulsida corporata limils, wr	ita RURAL and giva nearast town)
		WESTMUSTER	9420.	WEST	MINSTER	•
		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospi	ital, give street eddress)	d STREET ADDRESS		e. IS RESIDENC ON A FARM
	١	21 WARD AVE		21 W.	ARD AUE	YES NO V
	3.	NAME OF First	Middle	Last	4. DATE Mor	
	_	(Type or print) MAZIE	IKOPP	BLOCHE	DEATH /4	PRIL 3 1966
	5.	6. COLOR OR RACE 7. MARRIED	NEVER MARRIED 8	. DATE OF BIRTH	9. AGE (In year lest birthdey	Months Days Hours Min.
		finally wille widowed		Sept 4/8	94 7/ yrs.	
	N d	. USUAL OCCUPATION (Give kind of work 10b. KINg during most of working life, even if retired)	OF BUSINESS OR INDUSTR	A. BIRTHPURCE (Cour	ify & State, or foreign countr	y) 12. CITIZEN OF WHAT COUNTR
	/ <u>/</u>	SAPPLER'S NAME		14. MOTHER'S MAIDEN	m 11.9.	1 21.9.6
	"	Land Kalah		14. MOTHER S MAIDERY	ATOME ()	-1.0
	15	WAS DECEASED EVER IN U.S. ARMED FORKES? 16 S	OCIAL SECURITY NO. 17.	NEGRMANT	Ma Address	1004
		s, no, or unkown) (liyasgive wer or defes of service)	l	waltak.	0 / 5	935 Julianina ai
	=	18. CAUSE OF DEATH (Enter only one couse per lin		will the Co	ecorgic 1	INTERVAL BETWEEN
			CARDIAL	NEARCH	0N	ONSET AND DEATH
		1201 DUE TO		())) ,	per management date	
		Conditions, if any, which 7 (b) COR	ONARY AT	4EROSCLA	20515	7 YEAR
		gave rise to immediate cause		· -,	<u>*</u>	
		(a), steting the underlying Cause lest.				
	Z	PART II. OTHER SIGNIFICANT CONDITIONS CONT	RIBUTING TO DEATH BUT NO	T RELATED TO THE TERMI	NAL DISEASE CONDITION G	IVEN IN PART 1(0), 19. WAS AUTOPS)
	- 15					YES NO
	CERTIFE	OR CONTRIBUTING CAUSE OF DEATH	CRIBE HOW INJURY OCCURRE	D (Enter nature of injury i	n Pert I or Pert II of item 18.)	
		(IF EITHER, NOTIFY MEDICAL EXAMINER)				
	MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. In While		CE OF INJURY (Home, farm ory, street, office bldg., etc.		(County) (Stelle)
	뿧	p.m. 19 et work		010=	1 200	
		21. I certify that (I) (this hospital) attend				
		saw the deceased alive onAPRIL	./. , .19 (26., and that	death occurred at	M, from the causes	
		220. SIGNATURE			MED. STAFF	22b. DATE
		22c. PHYSICIAN'S	CUA M	22d. ADDRESS		710/66
		NAME (Type)		19 RIDG.	ERD, WES	THINSTER, MD,
	23	a. BURIAL, CREMATION, 23b. DATE THEREOF	23c. NAME OF CEMETERY	OR CREMATORY	23d. LOCATION (City,	State)
	1	201111 7/6/66	word Chief	n comelly	Bollman	
	24	EUNERAL DIRECTOR'S SIGNATURE	ADDRESS	77.00	TO BY REGISTRAR 256. F	EGISTRAR'S SIGNATURE
	_	- 1 mojers, fringer	INVIEW !	VIA - INFR	0 1966	conte judge.
	-	/ /			-	// //



1 4	M	ARYLAND STATE DEP	ARTMENT OF HEA	LTH	
Chall	DIVISION OF STATISTICAL R	ESEARCH AND RECORDS,		ET, BALTIMORE 1, A	MARYLAND
s ex X	<u> </u>	CERTIFICATE	OF DEATH		05100
the funeral rd 2 should seath.	PLACE OF DEATH		2. USUAL RESIDENCE (Who	are deceased lived, if institution	n: Residence before admission
by the land 2 death.	b. CITY OR TOWN (if outside corporale limits,	MARYLAND c LENGTH OF STAY IN 16	C. CITY OR TOWN (If outside	corporele limits, write RURAL	end give nearest lawn)
E- 2	WIDDALE BURG	9 MONTHS	WESTM	INSTER	~
rs. Pages hours afte	BROOKE IELD MAN	not in hospitel, give street address	RIDOAL		o. IS RESIDENCE ON A FARM? YES NO I
27 3.	NAME OF DECEASED (Type or print)	Middle	D last 4 DA		Day Year
. 15	SEX 6. COLOR OR RACE 7	MARRIED NEVER MARRIED B	DROWN	9. AGE (In years IF UND	
ent,	B USUAL OCCUPATION (Give kind of work	NIDOWED DIVORCED DIVORCED DIVORCED DIVORCED	-28-1872 YI 11. BIRTHPLACE (County & Stell	94 yrs.	Deys Hours Min.
2	opeduring most of working life, even if retired)	ATHOME	MARYL	AND	U.S.
hen please remo	FATHER'S NAME	DANI	14. MOTHER'S MAIDEN NAME	Dale	al Tomas II Sammers, South da
	WAS DECEASED EVER IN U.S. ARMED FORCE		NFORMANT	Addro RUR	AL MO.
-é _	18. CAUSE OF DEATH [Enter only one ca	NONENIE	SMAMIE ER	B, WESTM	INSTER
peri	PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (+)	ere has wround	in accident	• · ·	ONSET AND DEATH 2 how
burial-transit sl, cremation,	Conditions, if any, which	Donnal Cereb	varterische	wzis	3Vr5
40	geve rise to immediate cause (e), stating the underlying DUE TO		-		
2	PART II. OTHER SIGNIFICANT CONDITION	ONS CONTRIBUTING TO BEATH BUT NO	T RELATED TO THE TERMINAL DISE	ASE CONDITION GIVEN IN P.	ART 1(e), 19. WAS AUTOPSY
TIFICATION					PERFORMED?
Ü	20%. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH OF EITHER, NOTIFY MEDICAL EXAMINER	20b. DESCRIBE HOW INJURY OCCURRED	D. (Enter neture of injury in Peril) or	r Pert () of item 18.)	
MEDICAL	20c. TIME OF INJURY Month, Day, Year Hour a.m.		CE OF INJURY (Home, farm, 20f. ory, street, office bldg., etc.)	(City or lown) (0	County) (State)
	21. I certify that (i) (this hospital	i., d //	21965,		1966, that (1) (we) la
	saw the deceased alive on	PV 19.60, and that	1	trom the causes and or	the date stated above
	Julius (hopes _m		STAFF PHYS.	4/9/66 SIGNE
1	22c. PHYSICIAN'S Q JULIUS	Chepko	85/2 W. Green!	St. Westmins	ter Md
De III ed	BURIAL, CREMATION, 23b. DATE THEREO	6 METHODIS	OR CREMATORY 23d.	NID NITON	unity) (Stole)
NA	FUNDRIAL DIRECTOR'S SYGNATURE	ADDRESS D	25e. REC'D BY R	EGISTRAR 25b. REGISTRAR	'S SIGNATURE
	W. Jarryur 120-	ES UNION DEL	DGE/WAPR 12	1966 galian	Cas Judge



1 7	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLA	ND
£ 50 A	05102 CERTIFICATE OF DEATH	5101
hours after death. d in by the funeral rs. Pages 1 and 2 hours after death.	PLACE OF DEATH a. COUNTY a. STATE b. COUNTY b. COUNTY	fore admission)
after the the after	MARYLAND MARKET CARROLL	nearest town)
of filled in by the papers. Pages 1 hin 72 hours after	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 10 40 . Westminister	1
24 ho filled i papers. in 72 h	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e.	IS RESIDENCE ON A FARM?
hin 2 ely fi	295 20st Main At - YES 20st Main AT - YES NAME OF First Middle Cest 14. DATE Month Day	Year
completely we carbon event, with	(Type or print) GEORGE WILLIAM BROWN DEATH APRIL 18	1966
	SEX 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER1 YEAR IF	UNDER 24 HRS. Hours Min.
execusing and and an and In an	Oa. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF urbig most of working life, even if retired) INDUSTRY INDUSTRY	WHAT
cate be ophysician please nai, and In	traffic engineer rapid transit Carroll Co, ma 11.5.	a.
tifica ng ph nen p	3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME A PAGE 14. MOTHER'S MAIDEN NAME A PAGE	
r cer cendir it. T	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Address Conne	
at the death certification. ian. d by the attending phy transit permit. Then p cremation, or removal,	- 193-20-1668 Mrs Florence J. Brown address	AL DEPUSED
the n. by th ansit	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	AL BETWEEN AND DEATH
requires that the ding physician. been signed by the burial-transit or to burlal, crema	570) DUE TO INC.	
pires g phy en sig buri o bur	Conditions, if any, which gave rise to immediate pause (a) stating the DUE TO	
law requires that t attending physician. thas been signed b e as the burial-tran h prior to burial, cre	underlying cause last, (c)	
he la or att nte ha use a	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. W Cuturo Clause of Level Disease 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING OR CONTRIBUTION OR CONTRIBUTING OR	VAS AUTOPSY ERFORMED?
Tifficant for the of Head	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury-in Part for Part II of Item 18.)	110 5-1
PHYSICIAN: The the hospital or a the certificate detached for use the Dept. of Health		(State)
PAGE A TYENDING PHYSICIAN: The law to Page 4 may be retained by the hospital or attent TO FUNERAL DIRECTOR: After this certificate has director, page 3 should be detached for use as should be filed with the State Dept. of Health prior	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) factory, street, office bidg., etc.) factory, street, street, office bidg., etc.) factory, street, street, street, st	(State)
ATTENDING retained by CCTOR: After should be with the State	21. I certify that (1) (this hospital) attended the deceased from May 26, 19-3, to april 19, 1966, that	
OR ATTENDION OF AT	saw the deceased alive on 19 6, and that death occurred at 3 M, from the causes and on the date s 22a. SIGNATURE 22b. DATE SIGN	
AL OR ay be ay be sage filed	ATTENDING MED. STAFF DIRECTOR STAFF DIVENTED BY STAFF DIRECTOR DIVENTED BY STAFF DIV	6
O HOSPITAL Page 4 may O FUNERAL D director, pag should be fille	PHYSICIAN'S NAME (Type) JOHNS. HARSHEY M.D. BANCHOR ST. WESTMINSTER	MD
FO HOS Page TO FUN direct should	38. BURIAL, CREMATION, 23b. DATE THEREOF. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)	(State)
	24. FUNERAL DIRECTOR ADDRESS 25a. REC'DEN REGISTRAR 25b. REGISTRAR'S SIGNAT	URE
VR A15 (4) 15M 4-64	J. E. myers fr. Westminster, md. APR 2 2 1966 Charles Jud	



7d	1 (M)	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9	4 m24	05103 CERTIFICATE OF DEATH 05102
	death. funeral and 2 r death.	PLACE OF DEATH a. CDUNTY 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission, a. CDUNTY a. STATE b. COUNTY
	after / the 1 ges 1 after	Carroll Maryland Maryland Rollingra City
	thin 24 hours after the fight filled in by the front papers. Pages 1 within 72 hours after	b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH DF STAY IN 1b c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville l mo. 28 dys. Baltimore
4	filled in 72 ho	d. NAME DF HDSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. 15 RESIDENCE ON A FARM?
	in 2	Springfield State Hospital 2916 Harford Road YES ND NAME DF First Middle Last 14. DATE Month Day Year
	了 是责任	DECEASED (Type or print) Thomas Aloysins BROWN DEATH April 29 19 66
	e e e	SEX 6. COLOR DR RACE 7. MARRIED NEVER MARRIED 8. DATE DF BIRTH 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HR
	E .=	Male White WIDDWED DIVORCED 9-28-98 67 yrs. William Wind Wind Work William William
	cate be physician please ral, and in	ring most of working life, even if retired) INDUSTRY Machinist (retired) U.S.A. Was achined U.S.A.
	ficati g phy en p oval,	3. FATHER'S NAME
	cert	Thomas Brown Kitty Cant 5. WAS DECEASED FYER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
	death certifica e attending ph permit. Then ion, or removal	es, no, or unkown) (If yes give war or dates of service) No O12-05-0820 Records, Springfield State Hospital
		18. CAUSE OF DEATH [Enter only one cause ger line for (a), (b), and (c).] PART I, DEATH WAS CAUSED BY: ONSET AND DEATH DIST AND DEATH
	that ician ned I II-trai	IMMEDIATE CAUSE (a) MK/ ERIO Y CLEASTIC CARLIS WAS CHICA DISEASE / YEAR
	requires that the purity the purity or to burish	Conditions, if any, which gave rise to immediate (b) PERIPHERAL ARTERIOSCLEROSIS YEARS
	required noting the peet to or to	cause (a), stating the DUE TD
	atter atter has se as th pri	
	I: The all or all or use for use Health	PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO 20. ACCIDENT WAS UNDERLYING 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part II of Item 18.) OR CONTRIBUTING 20. CAUSE DF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
	PHYSICIAN the hospit this certi detached e Dept. of	
	Street, adapt	20c. TIME OF INJURY Month, Day, Year 20d. INJURY DCCURRED 20e. PLACE OF INJURY (Home, farm, Hour a.m. While at work at
	TENDING tained by FOR: Afte should be the Sta	21. I certify that (I) (this hospital) attended the deceased from 3-1-56, 19, to 11-29-55, 19, that (I) (we) las
4	ATT reta ECTO 3 shr with	saw the deceased alive on 4/29 1966, and that death occurred at 250M, from the causes and on the date stated above 22a. SIGNATURE O A 1
	IL OR By be DIR DIR Sage filed	ATTENDING MED. STAFF M.D. PHYS. DIRECTOR PHYS. f: 1-29-56
	HOSPITAL age 4 may FUNERAL rector, pa	NAME (Type) Samuel P. Wise, III, M.D. Sykesville, Maryland 2178)
	Page Page O FU direct	12. BURIAL, CREMATION, 23D. DATE THEREOF 23C. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
		ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
	VR A15 (4)	Butter A. Atalish Phylisistle Medicart 3 1966 governer Judge



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. death. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. COUNTY b. COUNTY Carroll after Maryland afte MARYLANO by the Pages b. CITY OR TOWN (if outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b papers. Page nin 72 hours a write RURAL and give nearest town) hours (Rural) Sykesville Baltimore City 21217 Om 13d d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled d. STREET ADORESS e. IS RESIDENCE 24 ON A FARM? Springfield State Hospital within Argyle Avenue YES No X within etely carbon NAME OF Middle Last Month Day DECEASED event, ARTUR compl 4 (Type or print) KISTO DEATH 29 66 19 6. COLOR OR RACE | 7. MARRIED 5. SEX AGE (in years IFUNDER 1 YEAR IFUNDER 24 HRS. last birthday) Months I Days Hours | Min. гетоме DATE OF BIRTH NEVER MARRIEO any Oays Hours and male Negro WIDOWEO WILL O WINORCED 12-7-75 .≡ 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT þ and COUNTRY? physici Md. unknown unknown USA certificate ъ 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME removal, attending ph ermit. The≡ unknown unknown 15. WAS DECEASED EVER IN U.S. ANMED FORCES? 17. INFORMANT ed by the attenctransit permit. 16. SOCIAL SECURITY NO. Address (Yes, no, or unkown) | (If yes give war or dates of service) Hospital Records, Sykesville, Maryland unknown unknown INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] ned by the I. DEATH WAS CAUSED BY: TERIOSE PROTIC IMMEDIATE CAUSE (a) been signed the burial-trainer to burial-trainer or to burial, cri 42 2 OUE TO Cenditions, if any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY for use Health PERFORMED? certificate Chronic brain syndrome associated with cerebral arteriosclerosis YES T NO 5d this cerum detached for PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF OFATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. OESCRIBE HOW INJURY OCCURREO, (Enter nature of injury in Part 1 or Part 11 of Item 18.) 20d. INJUNY OCCURRED (State) 20c. TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (Home, farm, 20f. (Clty or town) (County) factory, street, office bldg., etc.) Hour a.m. While at work p,m. the _66, to. 21. I certify that (this hospital) attended the deceased from 4_20 19_66, that (4) (we) last DIRECTOR: age 3 should lied with the and that death occurred at 232M, from the causes and on the date stated above. saw the deceased alive on. 22a. SIGNATURE 22b. DATE SIGNED þe page ATTENOING 4-29-66 M.O. OIRECTOR PHYS. O HOSPITAL FUNERAL 22c. PHYSICIAN'S 22d. ADDRESS director, p NAME (Type) Sam P. Wise III Springfield State Hospital NAME OF CEMETERY OR CREMATORY Sharp Street., noy Spring, Me (State) BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 5-4-66 Sandy ADDRESS REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR AI5 (4) 20M 1/65 1966 Mcliarles Judge



death. Page



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH and 2 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY Carroll a. STATE Mary Land by the finance large by the finance large Carrol1 MARYLANO b. CITY OR TOWN (if outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b write RURAL and give nearest town)
Rural, Westminster, Md. Rural, Westminster, Md. 15 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET AOORESS 6. IS RESIDENCE ON A FARM? Meadow View Nursing Home Westminster, Md. R. D. 2 within Westminster, Md. R. D. 1 YES NO K completely we carbon i Middle Mon th Oav Year DECEASED 1966 OF DEATH April Garfield David Crow1 (Type or print) 6. COLOR OR RACE | 7. MARRIEO AGE (In years | IF UNOER 1 YEAR | IF UNDER 24 HRS. last birthday) | Months | Days | Hours | Min. 5. SEX 8. DATE OF BIRTH NEVER MARRIED White Aug. 25, 1880 Male WIDOWED [DIVORCED [12. CITIZEN OF WHAT COUNTRY? 10a USUAL OCCUPATION (Give kind of workdone | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) death certificate be during most of working life, even if retired)
Retired Farmer INDUSTRY Carroll County, Md. Parm 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Julia Bankert David Crowl 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) ((If yes give war or dates of service) 219-01-4517A Bthel M. Smith, 400 Baltimore St. Hanover, Pa No 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN requires that the ONSET AND DEATH PART I. OEATH WAS CAUSED BY: years $a \in C$ been signed I the burial-trai or to burial, cri IMMEDIATE CAUSE (a) OUE TO Conditions, if any, which gave rise to immediate OUE TO cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? No X YES -20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) (State) 20c. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. While at work at work p.m. 21. I certify that (!) (this hospital) attended the deceased from and that death occurred at \$55ffM, from the causes and on the date stated above. saw the deceased alive on 22a. SIGNATURE ATTENDING PHYS. MED. DIRECTOR 22d. ADORES FUNERAL PHYSICIAN'S NAME (Type) BURIAL, CREMATION, 23Ь. OATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) REMOVAL (Specify) Silver Run, Carroll Co., Md. St. Marys Cemetery 4/29 Burial 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR VR ALS

1 . . 4 A A

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23 Film G375 4/21/66 _ mn CERTIFICATE OF DEATH 05107 by the funeral Pages 1 and 2 nours after death the law requires that the death certificate be executed within 24 haurs after death. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) . PLACE OF DEATH b. COUNTY a. STATE a. COUNTY Maryland Carroll MARYLAND Phove carban papers Pages I any event, within 72 hours after c, CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 b CITY OR TOWN ()f outside corporate limits write RURAL and give nearest town) yrs./6 mos Baltimore 21205 Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e IS RESIDENCE exadicampletely filled in ON A FARM? 3203 McElderry Street Springfield State Hospital YES NO TO 3. NAME OF DECEASED 4. DATE Year First Middle Last Doy OF 1966 DIEGETMAN April 8. Henry John DEATH (Type or print) 1 YEAR LIF UNDER 24 HRS. AGE (In years IF UNDER B. DATE OF BIRTH S SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED tast birthday) Manths Doys Hauts 11-19-1894 WIDOWED DIVORCED white male 11. BIRTHPLACE (County & State or foreign country) 12. CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR COUNTRY? during most of working life, even if retired)
Paperhanger INDUSTRY Marvland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME byrjal, crematian, ar removal Christine Offenstein Anthony Diegelman IS WAS DECEASED EVER IN U.S ARMED FORCES? 17. INFORMANT Address 16 SOCIAL SECURITY NO (Yes, no, ar unknown) (If yes give war ar dates af service) Springfield State Hospital Records INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a) (b), and (c) PART I DEATH WAS CAUSED BY signed by the burial-transit p ONSET AND DEATH ROMINOPNEUM IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (o), DUE TO stoting the underlying couse detached for use as the te Dept. of Health priar ta FUNERAL DIRECTOR: After this certificate has been WAS AJTOPSY PERFORMED? PART II. OTHER SIGNIFICANT_CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) MCEMIA FROM 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item 18.) 20e ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (State) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, 20f. (County) 20c. TIME OF INJURY Manth, Day, Year factory, street, affice bldg , etc.) Hour a.m Nat While at work at work 21. I certify that (1) (this hospital) aftended the deceased from 10-9-62 , 1966, that (1) (we) last 1966, and that death accurred at 2 M, fram causes and an the date stated abave. director, page 3 should should be filed with the saw the deceased alive an 220. SIGNATURE 22b DATE SIGNED STAFF PHYS. DIRECTOR & M.D. 22d ADDRESS Springfield State Hospital 22c. PHYSICIAN Robert N. Deeb. M.D. Sykesville, Maryland NAME (Type) 23d LOCATION (City or Town) (Stote) 23c. NAME OF CEMETERY OR CREMATORY (County) 23a. BURIAL, CREMATION, REMOVAL (Specify) 23b DATE THEREOF Butimor . d. Holy Redeemer 2 Buria. 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

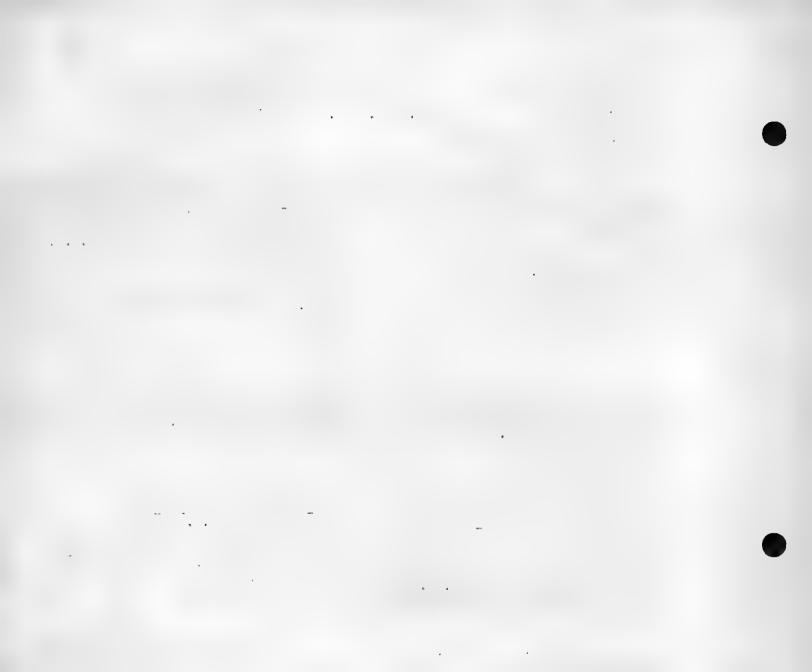
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 r death after death. 1. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) b. COUNTY completely filled in by the lave carbon papers. Pages 1 event, within 72 hours after Carroll Maryland MARYLAND Baltimore City b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) non 23 yrs. 8mos. 2dv Sykesville Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital Unknown YES NO 3 executed within 3. NAME OF Month First **AlbhIM** 4. DATE Year Last Day DECEASED (Type or print) JOSEPH NMN DEATH 19 Apri 6. COLOR OR RACE and con remove any eve 5. SEX AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS | last birthday) | Months | Days | Hours | Min. DATE OF BIRTH 8. 9. 7. MARRIED NEVER MARRIED TO Male Whi te 8-29 - 1886 WIDOWED DIVORCED [79 physician an please year, and analysis 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT death certificate be COUNTRY? Laborer Maryland U.S.A 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME гетома Christopher C. Dunn Amelia Eser 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address this certificate has been signed by the atten letached for use as the burial-transit permit. Dept. of Health prior to burial, cremation, or (Yes, no. or unkown) [(If yes give war or dates of service) No Unknown Records, Springfield State Hospital INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF OEATH [Enter only one cause per line for (a), (b), and (c), that the PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) the hospital or attending physician. Carcinoma of stomach months DUE TO Conditions, if any, which gave rise to immediate DUE TO (a), stating the underlying cause last. (c) Past II. Other significant conditions contributing to peath but not related to the terminal pisease condition given in Part 1(a) Chronic brain syndrome associated with alcohol intoxication, with CERTIFICATION WAS AUTOPSY PERFORMED? psychotic reaction.

20a. Accident was underlying of contributing of cause of Death (If Either, Notify Medical Examiner) YES NO 🖵 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part | or Part |) of Itom 18.) detached WEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (State) 20f. (City or town) (County) Ø Hour a.m. director, page 3 should be oshould be director, page 3 should be should be filed with the State Not While ATTENDING þ et work at work retained 19: 00M, from the causes and on the date stated above. 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 4-14-66 and that death occurred at SIGNATURE 22a. þe ATTENDING PHYS. STAFF PHYS. L-1L-66 Page 4 may b DIRECTOR 22c. PHYSICIAN'S Springfield State Hospital 22d. ADDRESS NAME (Type) Antonius Glahm, M.D. Sykesville, Maryland 2178h BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) Baltimore, Maryland 4/16/66 Raltimore Cemetery Burial REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS Milarles VR A15 (4) 1966 Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202 15M 4-64

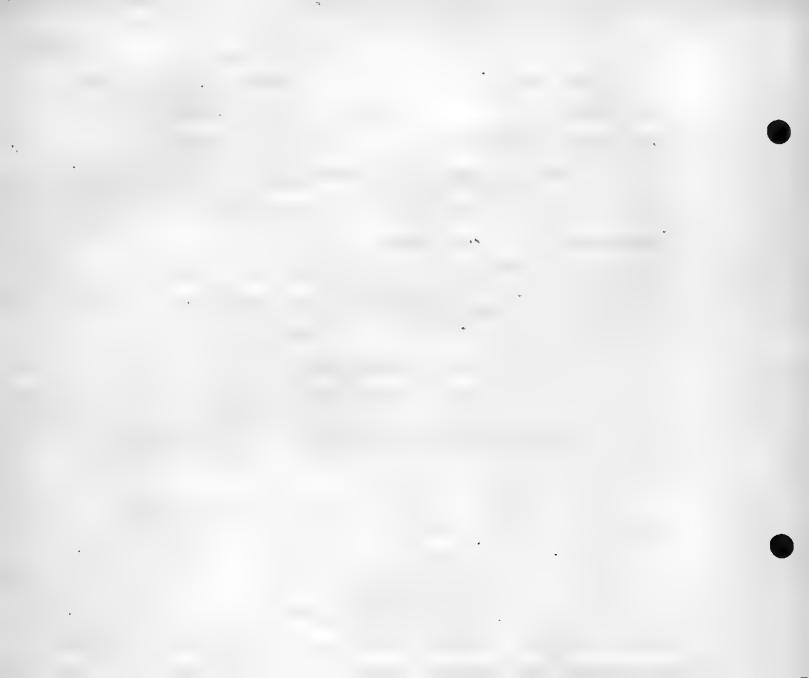


Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 OF DEATH CERTIFICATE 05109 requires that the death certificate be executed within 24 hours after death. death and campletely filled in by the funeral remave carban papers. Pages 1 and n any event, within 72 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) PLACE OF DEATH Carroll b. COUNTY o STATE MARYLAND No fixed address b. CITY OR TOWN (If autside carparate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give negrest tawn) Sykesville 1 mo. 2 dvs. No fixed address e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Springfield State Hospital YES 🗔 NO IX 3 NAME OF Middle 4. DATE First Last Manth Year DECEASED JOSEPH (NMN) ETON April 9 66 19 Type or print DEATH AGE (In years IF UNDER 1 YEAR IF UNDER S SEX 6 COLOR OR RACE B. DATE OF BIRTH 7 MARRIED NEVER MARRIED K 66 as bothowy) Months Haurs 10-18-1899 Male White WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT INDUSTRY COUNTRY? Massachusetts Unknown 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Unknown Unknown 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, na, ar unknown) (If yes give war or dates of service) þ Records, Springfield State Hospital Ukenown NTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY. signed by the burial-transit p ONSET AND DEATH radical Clarent IMMEDIATE CAUSE (c) DUE TO Canditians, if any, which gave rise ta immediate cause (a), as the prior to t stoting the underlying couse has been PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19. WAS AUTOPSY PERFORMED? NO K this certificate for 20a ACCIDENT WAS UNDERLYING □ 205. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) director, page 3 should be detache should be filed with the State Dept. 20c. TIME OF INJURY Manth, Day, Yeor Haur a m. 20d INJURY OCCURRED 20e, PLACE OF INJURY (Hame, form, (City or town) (County) (Stote) foctory, street, office bldg., etc.) After at work 21. I certify that (1) (this hospital) attended the deceased fram____ . 19 ., to 4/ --1925 that (1) (we) last 3-7-66 fo FUNERAL DIRECTOR: A director, page 3 should 19/66 and that death accurred at 230 AM, fram causes and an the date stated abave. saw the deceased alive an 22a. SIGNATURE 22b DATE SIGNED ATTENDING 4-9-66 M.D. PHYS 22c. PHYSICIAN 22d. ADDRESS Springfield State Hospital NAME (Lype) Robert M. Deeb. Sykesville, Maryland 2178h NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) 23c. BURIAL, CREMATION (County) (Stote) REMOVAL (Specify) -2Sg. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4)

MARYLAND STATE DEPARTMENT OF HEALTH



'NO!	1 (M	M	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
X	1 = 1	71	05110 CERTIFICATE OF DEATH
	death.	i	PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
	after of the fu		CARROLL COUNTY MARYLAND MARYLAND B. CONCARPOLL
	rs after by the Pages 1 urs after		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)
	hours id in by irs. Pa 2 hours	-	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE
•	24 hour filled in I papers. P		43 In UNI CTREET ON A FARM?
	uted within 24 hours after completely filled in by the vecarbon papers. Pages 1 event, within 72 hours after		. NAME DF First Middle Last I 4. DATE Month Day Year
	d with		Type or print) ROY CHARLES GAMBER DEATH APRIL 15 1966
	and com	_ ;	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min.
		1 1	WIDOWED DIVORCED 10G, 19, 1843 72 yrs.
	icate be explorate physician and please wal, and only only and only only only only only only only only		COUNTRY?
	phys		13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
	certifica Iding ph Then remova		KUBIN G. GAMBER MARY C. HARRIS
	th contractions and the contractions of the contraction of the contractions of the contraction of the contract		15 WAS DECEASED EVER INU.S. ARMED FORCES? 16. SOCIAL SECURITYNO. 17. INFORMANT Address 43 JOHN ST.
	dea he a per	2	18. CAUSE OF DEATH LEnter only one cause per line for (a), (b), and (c).
	requires that the death certificate be ding physician. Deen signed by the attending physician the burial-transit permit. Then pleaser to burial, cremation, or removal, and it		PART I. DEATH WAS CAUSED BY: ONSET AND DEATH
	that sicia med al-tra al, cl		14 4 1 DUE TO CONTROL OF THE CONTROL
	requires ding phy been sig the buri		gave rise to immediate (b) Cordioniscalle atherseleron &
			cause (a), stating the DUE TO Renal neerlno sclesosis C. anatamia onal nea
	law re attendii has be e as th	2	
	of a steam	7	YES NO X
	NG PHYSICIAN: The laby the hospital or att ter this certificate his detached for use attached for use tate Dept. of Health p	()	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Pert 1 or Part II of Item 18.) GOR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
	PHYSICI the hos this ce detache e Dept.	Menical	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) Hour a.m. While Mot Wh
		12	P.m. 19 While at work at work
	OR ATTENDI be retained IRECTOR: A: ge 3 should ed with the		21. I certify that (I) (this hospital) attended the deceased from 1966, to 4 1966, that (II) (we) last saw the deceased alive on 4 1 4 1 1966, and that death occurred at 5 2M, from the causes and on the date stated above.
	L OR ATTEND y be retaine DIRECTOR: age 3 should		22a. SIGNATURE // / D. D. DATE SIGNED
	. = 0		William & Occupie - M.D. ATTENDING MED. STAFF 4/15/66
		']	22c. PHYSICIAN'S NAME (Type) WILLIAM. R. O'ROURKE 150 W. MAIN ST. WESTHINSTERM
	TO HOSE 4 Page 4 TO FUNE directo	2	33. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
) _	BURIDE 4/18/66 ST. PAUL'S CEMETERY ARCADIA MD
	VR A15 (4)	4	Unes G. Saffell by. WESTHINSTER MD. DAPR 18 1966 goliantes Judge.
	20M 1/65	1	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05111 requires that the death certificate be executed within 24 hours after death deoth funerol 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o. STATE b. COUNTY ve carbon papers. Pages 1 event, within 72 hours after Carroll MARYLAND Maryland Baltimore City filled in by the fu papers. Pages 1 b CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lawn) c LENGTH OF STAY IN 16 Baltimore Svkesville 6vrs.6mos.12dvs d NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? 5905 Kayon Avenue Springfield State Hospital YES NO 🔼 3 NAME OF Middle 4 DATE First Doy eese remove carbon Lost Year ottending physicion and completely sermit. Then places remove carbon DECEASED AUGUSTA MMN GOLDERMAN APRIL 14 66 19 (Type or print) DEATH IF UNDER I YEAR IF UNDER 24 HRS. DATE OF BIRTH 9. AGE (In years S SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED lost birthdoyl Months Dovs Hours god July any e 2-1-1874 Female White WIDOWED DIVORCED 100 JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if refired) U.S.A. INDUSTRY Unk. Housewife. 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME burial, crematian, or removal John H. Lenhart Unk. 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no or unknown) (If yes give wor or dotes of service) permit. Records, Springfield State Hospital Unk. 18. CAUSE OF DEATH (Enter only one couse per time for (o), (b), ond (c).)
PART I DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p HTAD DEATH Arteriosclerotic heart disease IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove Generalized arteriosclerosis Years (b) rise to immediate couse (a), DUE TO as the prior tal stating the underlying couse peen Page 4 may be retained by the hospital or attending PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

CBS assoc. with cerebral arteriosclerosis, with psychotic reaction 19 WAS AUTOPSY PERFORMED? has be detached for use Stote Dept. of Health NO K this certificate 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20n ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. While Not While foctory, street, office bldg., etc.) of work ot work 21. I certify that (1) (this hospital) attended the deceased from 10-2-59 ond that death accurred of 11:50%, from causes and on the date stated above. 11-111-66 . 19 ... that (1) (we) last director, page 3 should should be filed with the 4-14-66 TO FUNERAL DIRECTOR: saw the deceased olive an. 22b DATE SIGNED 22o SIGNATURE MED. DIRECTOR ATTENDING STAFF PHYS. 4-14-66 M.D. 22d. ADDRESS Springfield State Hospital 122c. PHYSICIAN'S NAME (Type) Agustin del Campo / M. D. Sykesville, Maryland 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23o. BURIAL CREMATION (County) (Stote) REMOVAL (Specify) 4/16/1966 Loidon Park Cemeterv Baltimore, Maryland 25b. REGISTRAR S. SIGNATURE 2So REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

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	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND	AND
£ 80£	05.112 CERTIFICATE OF DEATH (151)	11
24 hours after death.	1. PLACE OF DEATH a. CDUNTY CARROLL MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence b a. STATE MARYLAND D. COUNTY CARRO	refore admission)
ours after in by the pours after hours after	b. CITY OR TOWN (if outside corporate limits, write RURAL and give system) b. CITY OR TOWN (if outside corporate limits, write RURAL and give system) c. CITY OR TOWN (if outside corporate limits, write RURAL and give system) 3 Weeks Rusal - Sykes Ville	nearest town)
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS / e.	IS RESIDENCE ON A FARM?
int, interest	3. NAME DF DECEASED (Type or print) POBERT N. HAMMOND 4. DATE Month Day OF DEATH APRIL 18	Year 1966
executed wand complements of any event,	Male White WIDOWED DIVORCED 5-9-1909 S6 yrs. Months Days	Hours Min.
	10a. USUAL DCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR II. BIRTHPLACE (County & State, or foreign country) 11c. CITIZÊN OF COUNTRY? 12c. CITIZÊN OF COUNTRY? 13. FATHER'S NAME	A,
生 必要を	W' Lee Hammond Josephine Forsythe	
ne death cer the attendir it permit Al	Yes WWII - MR. Arthur Hammond - Ellicott	City, No
es that the chysician. signed by the urial-transit purial, crematit	ONSET	AL BETWEEN TAND DEATH
PHYSICIAN: The law requires that the hospital or attending physician, this certificate has been signed betached for use as the burial-trane Dept. of Health prior to burial, cre	Conditions, if any, which gave rise to immediate (b) I when the alleast hemosphage 20	1 minute
law requir ttending p has been as the bl prior to b	cause (a), stating the DUE TD underlying cause last. (c) / Communal Capf Language PART II.D THER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119.	year.
CCIAN: The lands of the cost o	7 2 YES	VAS AUTDPSY PERFORMED?
PHYSICIAN: The the hospital or a this certificate detached for use e Dept. of Health		(State)
	Hour a.m. p.m. While Not While factory, street, office bldg., etc.) at work at work	
= 0 = H	21. I certify that (I) (this hospital) attended the deceased from	
TO HOSPITAL OR ATTENDING Page 4 may be retained by TO FUNERAL DIRECTOR. After director, page 3 should be should be filed with the Stat	22c. PHYSICIAN'S Sani Okutman 22d. ADDRESS South & SUITE, M. M. D. PHYS. South & SUITE, M.	66 d.
TO HOSPITAL Page 4 may TO FUNERAL director, page should be fight	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) BUTIAL (Specify) 4-21-66 OAK Grove Cemetery Howard Co.	(State)
VR AIS (4) 20M 1/65	24. FUNERAL DIRECTOR Hauf W. Haight Sykisible, Md. 25a. REG'D BY REGISTRAR 25b. REGISTRAR'S SIGNAT APR 2 5 1966 Charles Jan	٦



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* 1 (NA	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1.	MARYI AND
E = N	05113 CERTIFICATE OF DEATH	05112
er deat	1. PLACE OF DEATH a. COUNTY Carrell MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If Institution: a. STATE b. COUNTY MARYLAND	Residence before admission)
xecuted within 24 hours after death and completely filled in by the funeral enove carbon papers. Pages 1 and 2 enove carbon papers. Pages 1 and 2 enove carbon papers.	b. CITY DR TOWN (if outside corporate limits, write RURA write RURA and give nearest town) C. LENGTH OF STAY IN 1b C. CITY OR TOWN (if outside corporate limits, write RURA Write RURA A C C P P TOWN A C C P P TOWN A C C P P TOWN A C P	L and give nearest town)
24 hor 24 hor filled in 72 him 72 him	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	6. IS RESIDENCE ON A FARM? YES NO
vithin letely rbon r, with	3. NAME DF First Middle Last 4. DATE Month OF OF	Day Year
complication of the complex careful of the careful	(Type or print) (Y TA-CV (C P)CCC+ It CISTON DEATH ADTI	3 1966 RIYEAR FUNDER 24 HRS Days Hours Min.
	MINING WINDOWED DIVORGED 5/5/100 80 yrs.	Days Hours Min. CITIZEN OF WHAT COUNTRY?
ite be ysicia please 1, and	Housende, Wyginia	COUNTRY?
ertifica ing ph Then emoval	13. FATHER'S NAME Vicholas Hensley Columbia Francis	
aw requires that the death certificate be executed within tending physician. The attending physician and completely as been signed by the attending physician and completely as the burial-transit permit. Then please femove carbon prior to burial, cremation, or removal, and in any event, with	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITYNO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) 2/5-07-633 Chrustine Gaucher Main	herter ud.
the d n. by the nnsit p	18. CAUSE DF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN ONSET AND DEATH
s that hysicia signed rrial-tra	4201 DUE TO Conditions, If any, which) DUE TO Conditions, If any, which)	- 8ms
law requires that that the difference of the signed been signed been signed been so the burial-tranthy prior to burial, creather the signer of	gave rise to Immediate cause (a), stating the DUE TO	
ne law r atten te has se as ith pri		PERFORMED?
ING PHYSICIAN: The law requires that is by the hospital or attending physicial after this certificate has been signed be detached for use as the burial-transfate Dept. of Health prior to burial, state Dept.	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Occupant Was Underlying 20b. Describe How Injury Occurred. (Enter nature of Injury In Part I or Part II of Item 1 (IF EITHER, NOTIFY MEDICAL EXAMINER)	8.) YES NO
PHYSICIA the hospi this cert detached e Dept. of		ounty) (State)
OING P ed by t After Id be d	p.m. 19 at work at work 21, 1 certify that (i) (this hospital) attended the deceased from Nov 1947, to 473, 196	6_, that/IT (we) last
ATTENDING retained by CTOR: Afte S should be with the Sta	saw the deceased alive on 4// 1966, and that death occurred at \$230 M, from the causes and on	the date stated above.
AL OR ay be page affled y	M.D. ATTENDING MED. STAFF PHYS. 22c. PHYSICIAN'S DIRECTOR PHYS. 22d. ADDRESS	44166
O HOSPITAL OR ATTENOM Page 4 may be retained O FUNERAL DIRECTOR: Af O FUNERAL DIRECTOR: Af Should be filed with the S	NAME (Type) W. H. TO A. P. MANCHESTET	Md.
DE SE	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or community and community	. bM
VR £15 (4)	24. FUNERAL DIRECTOR ADDRESS Tipton-Eline Fun. Home, Hampstead, Md. DATAPR 7' 1966 Click	les Judge
20M 1/65		00



I (No	MARIEAND JIME DELARIMENT OF TEACHT DALIMORE, TO
	05114 CERTIFICATE OF DEATH Reg. Dist. No. 05113
ge 4 with	1, PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 3. STATE 4. COUNTY
Po dire- filed	6. COUNTY Carroll Maryland 6. COUNTY Carroll
deoth nerol	b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
op E	RURAL and give nearest town Rural Taneytown Rural Taneytown
o te	d. NAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION B IS RESIDENCE ON A FARM?
2 4 2 P	P.O. Route # 1M P.O. Route # 1M YES X NO [
og in B	3 NAME OF First Middle Last 4. DATE Manth Day Year DECEASED OF A ST
n 24 Fillec	(Type or print) BITCLE BELLE HESS DEATH APPLL 6 1966
within Poge	S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED X 8. DATE OF BIRTH 9. AGE (In years lost birthday) Manths Days Hours Min
	Female White widowed Divorced December 28, 1890 75 yrs. Manins Days Hours Min
executed to complete to popers.	10a. USUAL OCCUPATION (Give kind of work done of the first of work done) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY 12. CITIZEN OF WHAT COUNTRY 13. BIRTHPLACE (State or foreign country)
	Housework None Maryland U.S.A.
A CTA	13. FATHER'S NAME
physicion move cor hours offi	Richard Hess Mary Hahn
requires that the death certificate on. I signed by the ottending physicion sit permit. Then please remove co nd in any event within 72 hours of	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (if yes, give wer or dates of service)
ing ing	No None Mrs. Ralph Shipley R#1M Taneytown, Md.
feotl lend leos rthir	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY. ONSET AND DEATH
he den p	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c) Cere land land land land land land land land
of the The The	332X DUE TO
A do you	Conditions, if any, which (b)
gne in c	cod'se (o), stating the <u>under.</u> DUE TO
red ion. ion nsit ond	lying cause last.) (c)
low ysic bee bee ol,	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? YES NO
The physical	YES NO
FAN: Vending	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
SIC r off fron	20c. TIME OF INJURY Month, Day, Year Hour o. m. P. m. 19 Od. INJURY OCCURRED While Not while of work
PHY bis of use bmo	Hour o. m. p. m. While Not while of work of
Parities in the second	21. I certify that I attended the deceased from 7/5/44 19 to 4/4/4, 19 that I last saw the deceased
d of policies	alive on 4/5/66, 19, and that death accurred at 2.13 1/1 M, from the causes and an the date stated above
H t	ADDRESS (Street, city or town, stote) DATE SIGNED
d by de control	SIGNATURE M. E. Kobertson M.D. Level Windows Und 4/4/4/4
O de la	PHYSICIAN'S M & Robertson
rete RAL Shot stroi	NAME (Type) M.E. Robertson New Windsor, Md.
HOSPI oy be FUNER oge 3 o	220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State)
moy be of FUNER poge 3 s	Burial 4/8/66 Lutheran Cemetery Taneytown, Maryland
not	23. FUNERAL DIRECTOR'S SIGNATURE 246. REGISTRAR 246. REGISTRAR'S SIGNATURE
VS A1S (4) 15M 9/S5	C.O. Fuss & Son Taneytown, Maryland ARR 7 1966 (Charles Judge



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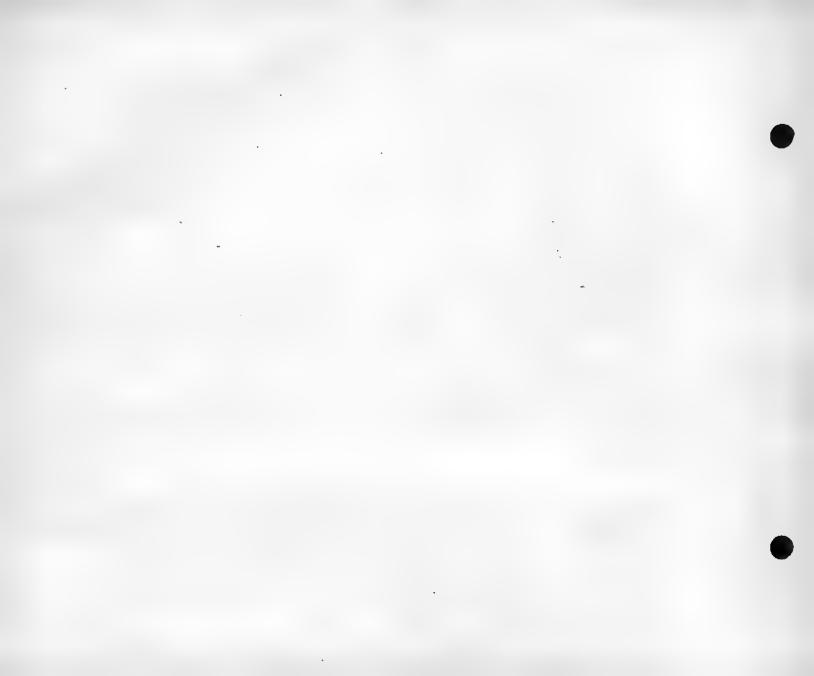


DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Whara deceased lived, if institution, Residence before admission) a. COUNTY Baltimore 22 Corrol Tarvland MARYLAND and b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Syresville Baltimore 21 vears d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? Pullen Mursing H 1724 Glen Curtis YES NO 3. NAME OF 4. DATE DECEASED OF (Type or print) DEATH Luthe Holt. April 1966 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS death certificate be lest birthday) Male WIDOWED [" 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 112. CITIZEN OF WHAT COUNTRY done during most of working life, even if retired) Sanitation Martin Frederick Co. . Md. Dent. please .⊆ 13. FATHER'S NAME Lucinda Stottlemyer Charles Holt 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unkown) (Ifyes give war or detes of service) Balto. attending physician. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). has been signed by INTERVAL BETWEEN ŏ ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Diabetes, severe: Caronary thrombosis: IMMEDIATE CAUSE (a) 1965 160 X through DUE TO Cardiac failure: Pneumonia: Conditions, if any, which April 17 gave rise to immediate cause 1966 (a), stating the underlying Cerebral vascular accident. use as I PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS CERTIFICATION PERFORMED? prior No 🗸 20a. ACCIDENT WAS UNDERLYING IT 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) of Health OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Yaar 2Dd. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. Not While DIRECTOR: al work at work p.m. saw the deceased alive on April 17 19.66., and that death occurred a 5:35% from the causes and on the date stated above 22a. SIGNATURE 22b. DATE page 3 s with the death. Page 4 a director, page 3 director, page 3 be filed with the HOSPITAL PHYS. DIRECTOR PHYS. Page 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Howard E. Hall. M.D. Sykesville. Maryland 23a. BURIAL, CREMATION, 1 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City, Jown or county) REMOVAL (Spacify) Frederick ADDRESS 24 FUNERAL DIRECTOR'S SIGNATURE Waltz VR A15 [4] Pox 241 Sykesville, Md. 2DM 5-63

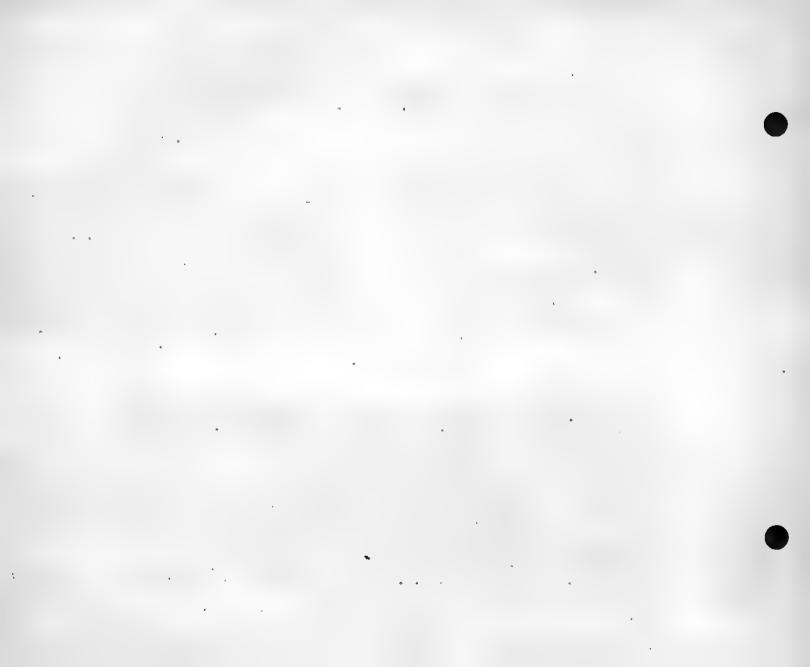
MARYLAND STATE DEPARTMENT OF HEALTH



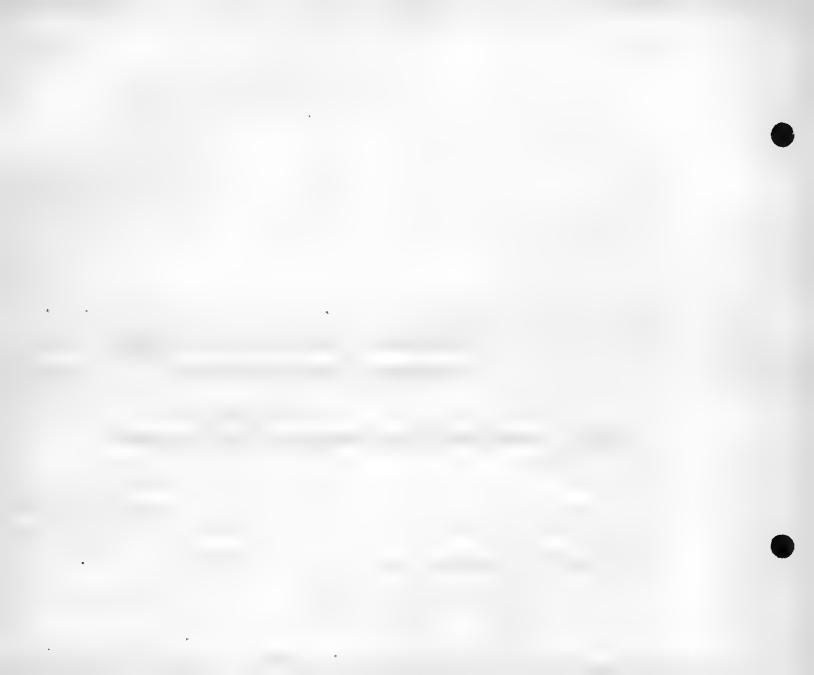
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05116 CERTIFICATE OF DEATH and 2 death. law requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission PLACE OF DEATH physician and campletely filled in by the funeral o. COUNTY b. COUNTY oan papers. Pages 1 within 72 hours after MARYLAND c. LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits, extiside carporate limits, write RURAL and give nearest town? write RURAL and give nearest lown) e IS RESIDENCE ON A FARM? d. STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street piddrass) NO Z NAME OF Midd e 4. DATE Month Day First Lost Year DECEASED (Type or print) DEATH 19 F UNDER 1 YEAR IF UNDER 24 HRS. S. SEX AGE (In years 6. COLOR OR RACE 7 MARRIED ₿ NEVER MARRIED lost birthdoy) Months Doys Hours DIVORCED WIDOWED 12 CITIZEN OF WHAT 10o JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) COUNTRY? during most of working life, every if retired) 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAMI ar remayal, WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOC AL SECURITY NO 17. INFORMAN Address (Yes, no, or anknown) [If yes give wor or dates of service] burial, crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c). signed by the burial-transit p ONSET, AND DEATH PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) **DUE TO** Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) USe NO YES the haspital ar þ 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (Stote) TIME OF INJURY Month, Doy, Year Hour a.m. foctory, street, office bldg., etc.) Not While at work of work pe. 21. I certify that (1) (this haspital) attended the deceased fram Chill 6 , 1966, ta Coffsel 9, 1966, that (1) (we) last be retained 19.66, and that death accurred at 2.45 M, from causes and an the date stated above. saw the deceased alive an 22o SIGNATURE 22b. DATE SIGNED director, pay M D DIRECTOR PHYS. 22d ADDRESS 22c. PHYSICIANUS NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City or Jown) 23o. BURIAL, CREMATION 23b. DATE THEREOF (County) (Stote) EMOVAL (Specify) 250 REC'D BY REGISTRAR FUNERAL DIRECTOR **ADDRESS** VR A15 (4) 20 M 1/66



1 (2)	MARYLAND STATE DEPARTMENT OF HEALTH
FOR STATE	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HEALTH DEPT.	1. PLACE OF DEATH 31 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admiss)
~~~ a	Carroll Maryland Maryland Montgomery
cessary, may be may be partment	b. CITY OR TOWN (if outside corporate limits, write RURAL end give nearest town)  c. CITY OR TOWN (if outside corporate limits, write RURAL end give nearest town)
cess te fun may spartm	Sykesville 6 yrs./25 das Silver Spring / 2 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDEN
3 to the Page Page Late De lurs aff	ON A FARM
e e	3. NAME OF First Middle last 14 DATE Month Oay Year
PM3.	OFFICIAL DECEASED (Type or print) Geraldine Marie JONES DEATH April 2, 19 66
h. If a lorm lorm ! within within	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. OATE OF BIRTH 9. AGE (in years If UNDER 1 YEAR IF UNDER 24H last birthday) Months Days Hours MI
Page th for	TO TO TO TO YES.
with with	10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  10b. Kind of Business or lindustry  11. BIRTHPLACE (State or foreign country)  Maryland  12. CITIZEN OF WHAT COUNTRY?  Waryland  13. BIRTHPLACE (State or foreign country)  Local State of Foreign Country (COUNTRY)
ong Cong	none – Maryland U.S.A.  13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
ours e al	Robert F. Jones Ida Marie Spreen
24 ho n Item Office File	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
within pencil li miner's permit. removal,	no Springfield State Hospital Records
d wil	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY:  INTERVAL BETWEE ONSET AND DEATH MILES OF THE COURSE (A) A SIND DEATH MILES OF THE COURSE (A
lid be executed   "pending" in   "medical Exam   burlal-transit     cremation, or	1/2/2 frankflirtan.
exending discarding al-tra	Conditions, if any, which \ Pulmonary edema. mins.
d be "ped", Med Med	geve rise to immediate cause (a), stating the OUE TO
should word Chief as a a	underlying couse lest. (c)
a a a a	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL OISEASE CONDITION GIVEN IN PART I(e)  PERFORMED  Without qualifying phrase. Encephalitis in childhood.  Without qualifying phrase. Encephalitis in childhood.  YES NO  PREME TI. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL OISEASE CONDITION OF PERFORMED  VICTOR OF THE PROPERTY OF CONTRIBUTION OF THE PROPERTY OF THE
rifficang the property of to the use or to	without qualifying phrase. Encephalitis in childhood. YES X NO [ 208. EXTERNAL CAUSE WAS 200. DESCRIBE HOW INJURY OCCURRED. (Enter nature of latery in Part 1 or Part 1) of item 18.)
a in the second of the second	20a. EXTERNAL CAUSE WAS PRIMARY DO CONTRIBUTING CAUSE OF DEATH.  20a. EXTERNAL CAUSE WAS INCOME TO CONTRIBUTING CAUSE OF DEATH.  20a. EXTERNAL CAUSE WAS INCOME TO CONTRIBUTING CAUSE OF DEATH.  20a. EXTERNAL CAUSE WAS INCOME TO CONTRIBUTION CONTRIBUTION CAUSE OF DEATH.
R: This ate, wr forward 3 shour age≡t,	
INER:	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)  12:45 p.m. 4/2 19 66 While Not While At work Hospital Sykesville Carroll Md.
Tab. det	21. I certify that I took charge of the remains described above, held an Autopsy (), Inspection (), Inquiry (), and in my opini
EXA the ce shoul files. TOR: design	death resulted from: Natural causes, Accident X, Suicide , Homicide , Undetermined manner
et a So E st	ACTUAL SIGNATURE AND ASSISTANT MEDICAL EXAMINER (22. DATE SIGNE
Y ME Executed for tor hor	DEPUTY MEDICAL EXAMINER
DEPUTY lease ex irector. stained f FUNERAL	NAME (Type) W. Gienn Speicher, M.D. Adapted (Street Aug. advancy) Annual Carrier II
TO DEPL please director retain TO FUNI of Hea	C REMOVAL (Specify) 1/2 - 1/2 Manager 1 Carety 1 mg
	24. FUNERAL DIRECTOR 25b. REGISTRAR'S SIGNATURE
VR AL5ME (5) 5M 1/65	Harry Weer Haight Sykewille, Md. APR 6 1966 goliantes Judge



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death puo PLACE OF DEATH deat 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) ° CARROLL o. STATE MARYLAND Maryland Carroll C LENGTH OF STAY IN 16 b CITY OR TOWN (If outside corporate I mits, write RURAL and give nearest town) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) days Rural - Hampstead WESTMINSTER d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. 15 RESIDENCI completely filled in d. STREET ADDRESS ON A FARM? County General Hospital YES NO TO corban NAME OF Middle 4. DATE Month Year Lost Doy DECEASED OF Keller Alverta May 1966 (Type or print) DEATH IF UNDER 24 HRS. S SEX 6 COLOR OR RACE 7. MARRIED B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR NEVER MARRIED last birthdoy) 82 yrs Months Doys Hours Female White 1883 WIDOWED DIVORCED June 1 12. CITIZEN OF WHAT 10b KIND OF BUSINESS OR 100 USUA, OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & Store, or foreign country) during most of working life, even if retired) USA? INDUSTRY ottending physicion permit. Then pleasi Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removo unknown Steven G. Lloyd 15 WAS DECEASED EVER IN J.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service Mrs. Gilbert Keller, Upperco, Md. no cremation, 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the buriol-tronsit p buriol, cremati INSUFFICIENCY CEREBRAL IMMEDIATE CAUSE (o) DUE TO CEREBLAL ARTERIO SCLEFOSIS Conditions, if ony, which gove (b) rise to immediate couse (a), DUE TO for use as the b Health priar to b stoting the underlying couse has been lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? ARTERIOSCLEROTIC HEART DISEASE-DECOMPENSATED (2) BRONCHOPNEUMONIA NO C O FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) 20c. TIME OF INJURY Month, Doy, Year (County) (Stote) Hour o.m. factory, street, office bldg, etc.) Not While ot work 44/12, 1966, that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. 1966 to 4 moy be retained and that death accurred at 6.35 M, fram causes and an the date stated above. saw the deceased alive an 220 SIGNATURE 22b DAJE SIGNED STAFF ATTENDING director, page 3 should be filed v M.D. DIRECTOR PHYS PHYSICIAN S NAME (Type) 22d. ADDRESS 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b. DATE THEREOF 23o BURIAL CREMATION (County) (Stote) Burial (Specify) Evergreen Mem. Gardens Finkeburg. 4/15/66 FUNERAL DIRECTOR Tipton-Eline Funeral Home, Hampstead 2So REC'D BY REGISTRAR 2Sb. REGISTRAR S SIGNATURE 24 FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 r death 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before numission a. COUNTY letely filled in by the furbon papers. Pages 1 and within 72 hours after d b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits. c. CITY OR TOWN (If outside corporate limits, write BURAL and give neavest Yown) write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address 6. IS REQUEENC d. STREET ADDRESS ON A FARM? NO K YES etely inted within carbon NAME OF Middle DATE Month DECEASED DIE event, (Type or print) DEATH 5. SEX IF UNDER 14 EAR IF UNDER 24 HRS CDLOR OR RACE DATE OF BIRTH AGE (In years 7. MARRIED гетоуе last birthday) | Months | Davs any and WIDOWED 💢 DIVORCED [ 10b. KIND OF BUSINESS OR INDUSTRY ACTION LINE Ξ 10a. USUAL OCCUPATION (Give kind of work done | BIRTHPLACE (County & State, or foreign country) 12. CITIZEN DF WHAT the attending physician t permit. Then please ration, or removal, and in during most of working life, even if retired) death certificate 13. FATHER'S NAME MOTHER'S MAJOEN NAMI 15/ WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Yes, no, or unknown) ((If yes give war or dates of service) 1-transit perm 1, cramation, o None 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c) INTERVAL BETWEEN requires that the DNSET AND DEATH PART I. DEATH WAS CAUSED BY: or attending physician, been signed the burial-transfer or to burial, cra IMMEDIATE CAUSE (a) **DUE TO** Conditions, If any, which gave rise to immediate DUE TD cause (a), stating the underlying cause last, PHYSICIAN: The law NO PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTDPSY for use Health PERFORMED? certificate CERTIFICATI YES X ND T 20a. ACCIDENT WAS UNDERLYING TO DR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury in Part | or Part | of item 18.) p detached de Dept. of (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) be de State I factory, street, office bldg., etc.) Hour a.m. Not While While After ATTENDING at work at work director, page 3 should should be filed with the 1906 to 21. I certify that #0 (this hospital) attended the deceased from 1966, and that death occurred at 752M, from the causes and on the date stated above. saw the deceased alive on. 22a. SIGNATURE DATE SIGNED STAFF M.D. PHYS. DIRECTOR may O HOSPITAL 22c. PHYSICIAN'S 22d. **ADDRESS** NAME (Type) BURIAL, CREMATION, REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY 23b. 23d. LOCATION (City, town or county) (State) ancaster Cemeteru Penna. REGISTRAR'S SIGNATURE 25a. REC'D BY REGISTRAR VR A15 (4) 20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05120 CERTIFICATE OF DEATH requires that the death certificate becamecuted within 24 hours after death and dad completely filled in by the funeral 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Carroll MARYLAND Md. Balto. c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 16 Westminster Reisterstown e IS RESIDENCI ON A FARM d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Carroll County General Hospt. Dover Road YES NO NAME OF Middle First Lost 4. DATE Month Doy Year DECEASED 0F Park Daniel Kieffer 1966 DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX 6 COLOR OR RACE DATE OF BIRTH 7 MARRIEO **NEVER MARRIED** birthdoy) Months Hours Dovs Oct. 3, 1886 Male White and in any WIDOWED 100 USUAL OCCUPATION (Give kind of work done 1Db K ND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT ease ducing most of working life, even if cetired). Election Board of INDUSTRY COUNTRY? signed by the attending physician burial-transit permit. Then please burial, crematian, ar removal, and i Baltimore Co. Md. Baltimore County IISA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Stephen Kieffer Loflin Ruth 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT Address 16. SOCIAL SECURITY NO (Yes no, or unknown) (If yes give wor or dotes of service) 218-12-6502 Reisterstown, Md. Mrs. Rabeth S. Kieffer INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY CEREBRAL IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physicion. DUE TO 2 WEEKS BRONCHOPNEUMONIA -RUL +RLL Conditions, if any, which gove rise to immediate couse (a), DUE TO stating the underlying couse at tor use as the af Health priar ta O FUNERAL DIRECTOR: After this certificate has been lost. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) WAS A JTOPSY PERFORMED? EMPHYSEMA NO TH 20o ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Hour o.m factory, street, affice bldg., etc.) Not While 1966 , 1966, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased from director, page 3 should should be filed with the 19 66, and that death accurred at 8 28 M, from causes and an the date stated above saw the deceased alive an 22o, SIGNATURE DATE SIGNED ATTENDING DIRECTOR 22d ADDRESS 22c PHYSICIAN'S NAME (Type) NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) REMOVAL (Specify) 4/20/66 Pleasant Grove Cemetery Boring. 24. FUNERAL DIRECTOR VR A15 (4) Eline & Sons Reisterstown, Md. 20 M 1/66



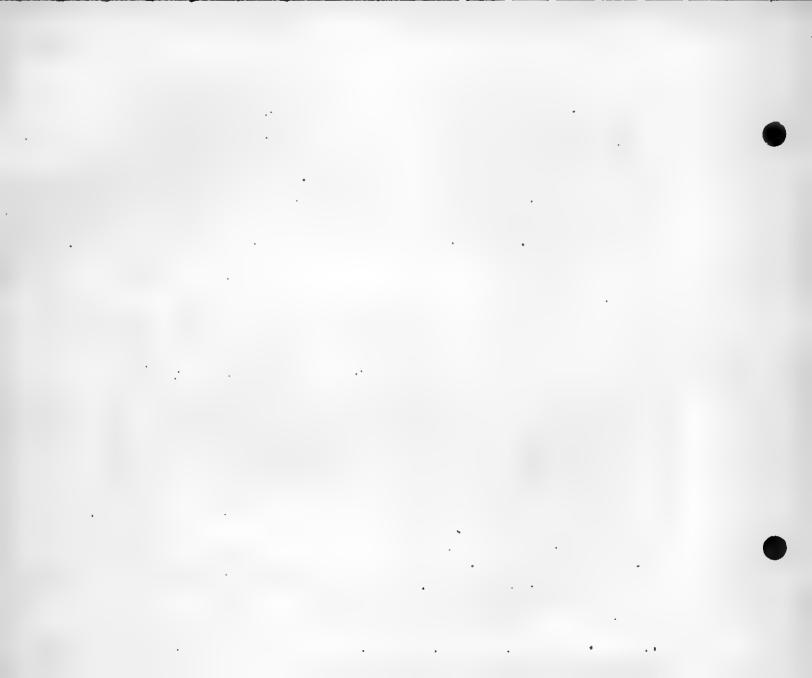
1 -		MARYLAND STATE DEPARTMENT OF HEALTH
The same of the sa	1	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	4	15121 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 15121
MEALTH DEPTS	1.	PLACE OF DEATH  2. USUAL RESIDENCE (Where decesed lived, if institution, Astrono before adjuss on)  a. COUNTY  b. COUNTY
1/1 E . 8 5	}	Carroll Maryland 6. COUNTY ( CARROLL MARYLAND
S. C. E. E. C.		b. CITY OR TOWN (if outside corporate limits, write RURA) and give nearest town write RURAL and give nearest town
ector.		Manchester Manchester C/c - /
For y Board		d NAME OF HOSPITAL OR INSTITUTION (if not in hospita, g va street address)  d. STREET ADDRESS  o. IS RESIDENCE ON A FARM?
4 0 9 40	_	Rte. 1 Rte.1 YES NO
E T T T T T T T T T T T T T T T T T T T	3.	NAME OF First Middle Last 4. DATE Month Day Year DECEASED OF , 14
the state of the s		(Type or print) Homer A. Leinart DEATH 4 II 19 00
death death	5.	SEX 6. COLOR OF RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH  9. AGE (In years   IF UNDER 1 YEAR   IF UNDER 24 HRS. (as birthday) Months Days Hours Min.
Page 2		INSTE   WILLE   WIDOWED   DIVOKED
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A 4 h	13.	FATHER SWAME 14 MOTHER'S MAIDEN NAME
F F F F F F F F F F F F F F F F F F F	_	John Remark Union Horris
S. Correction of Fig. 6.		WAS DICEASED EVER IN U.S. KRAED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (If you go wear or detes of service)
ed virial dy		1 18. CRUSE OF DEATH lenter only one cause per line for (a), (b), and (of.)
bxecut il in ite long v ans:t p ad in a		PART (, DEATH WAS CAUSED BY) Contamination of Contamination
alor rran		IMMEDIATE CAUSE (a) Carbon monoxide Koisoning
d by		7 / 5 / DUE TO
shoul s Off a bu		Conditions, if any, which (b)  gave rise to immadiate cause
20 N L		(a), staling the underlying DJETO
ertificate 1 "pendir Examiner s used as	Z	COUNTRIBUTION TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY
vord " vord " cal Ex d be u ematic	CERTIFICATION	PERFORMED? YES X NO 1
× ded and	15	20a. EXTERNAL CAUSE WAS   20b. DESCR BE HOW INJURY OCCURED. (Entar natura of Injury in Part II of Item 18.)
Medial, cu	E	PRIMARYX or CONTRIBUTING   inhalation of auto exhaust fumes
MINE rriting Chief oge 3	Z	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20a. PLACE OF INJURY (Horns, ferm, 20f. (City or lown) (County) (State)
A Manage	MEDI	Hour s.m.  7 p.m. 4 11 19 66 at work at work 1 home Manchester Carroll Md.
Prior Prior	~	21. I certify that I took charge of the remains described above, held an Autopsy . Inspection . Inquiry . and in my opinion
M L EX te ficate forwarded to the L DIRECTOR: ated egent, prio		death resulted from. Natural causes , Accident , Suicide X, Homicide Undetermined manner
BEG		CHIEF MEDICAL EXAMINER
Z o o o		SIGNATURE ASSISTANT MEDICAL EXAMINER TO DATE SIGNED
P. P		DEPUTY MEDICAL EXAMINER
DEPUTY sesse exect should be FUNERA its design		NAME TYPIWerner U., Spitz, M.D. Address (Streat, city, town, or county) 4/12/66
	22	S. BURIAL, CREMATION, 226. DATE THERTOF 226 NAME OF CEMETERY OF CREMETORY 226 NOCATION (CITY 19W), or flustry of the control o
0 <u>v</u> 4 0 g	1	ENNIED AL DIRECTOR
VS. A15ME	2:	- H 26 The clarice 1 Bulgar PR 1 4 1966 The aller States
5M 9-60	14	affect 1. Inwally
		"Tricker Luneral Hotel



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH should within 24 hours after PLACE OF DEATH 2. USUAL RESIDENCE (Where decaesed lived, if institution: Razidance e. COUNTY b. COUNTY by the land 2 death. Carroll MARYLAND Maryland Carroll b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN lif outside corporate limits, write RURAL and give nearest lown write RURAL and give nearest town) filled in hours after Pages Middleburg
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) New Windsor d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Brookfield Manor Nursing Home Church Street YES NO ... Daber 3. NAME OF 4. DATE Year Month Dev DECEASED OF (Type or print) DEATH H. 1966 Florence Lindsav 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years LIF UNDER 1 YEAR IF UNDER 24 HRS lest birthday) Months Deys WIDOWED -DIVORCED T 10a. USUAL OCCUPATION (Give kind of work 105, KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if ratirad) Housekeeper Own home Maryland please .⊆ 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME pue Martha Repo Theodore Harman loval, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17, INFORMANT (Yas, no, or unknwn). (If yas giva war or datas of service) Westminster, Md. None Russell Lindsay 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). Š ONSET AND DEATH PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cremation, 4351 DUE TO Conditions, if any, which gave rise to Immadiate cause DUE TO (a), stating the underlying cause last. certificate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(+) 19. WAS AUTOPSY hospital SE 0 CERTIFICATION PERFORMED? use prior YES NO T for 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II or Part II of item 18.) etached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY 20d. INJURY OCCURRED 2Ge, PLACE OF INJURY (Home, farm, ) (State) Month, Day, Year 20f. (City or fown) (County) ö factory, street, office bldg., etc.) While Not While DIRECTOR at work at work D.m. 21. I certify that (I) (this hospital) attended the deceased from. P 4.19. and that death occurred at 6.45 Prom the causes and on the date stated above. shoul saw the deceased alive on...... 22b. DATE 22e. SIGNATURE SIGNED HOSPITAL FUNERAL page DIRECTOR PHYS. PHYS. M.D With 22c. PHYSICIAN'S 22d. ADDRESS NAME (Typa) filed v Robertson 23a, BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) O.F.S REMOVAL (Spacify) New Windsor Rural  $\operatorname{Md}$  . Bethel Burial Cemeterv 25a, REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE ADDRESS 24 FUNERAL DIRECTOR'S SIGNATURE 2DM 5-63



pro #	1 (M	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
	= =0	05123 CERTIFICATE OF DEATH (15122
•	executed within 24 hours after death.  and completely filled in by the funeral removed carbon papers. Pages 1 and 2 in any event, within 72 hours after death.	1. PLACE OF OEATH a. COUNTY A. C. LENGTH OF STAY IN 1D B. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) A. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) A. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) A. STREET ADDRESS A. STATE A. DATE ON A FARM? YES ON A FARM? YES ON A FARM? YES NO STATE A. DATE OF HOTH A. DATE A.
	e be rsiciar lease and i	SALES man UNKnown MD.
	e death certificate be executed wi the attending physician and comple t permit. Then please removed fart ation, or removal, and in any event,	13. FATHER'S NAME  Service LUTZ  15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 220-18-2628 HOSP: +a L Record —
	The law requires that the lor attending physician. cate has been signed by ir use as the burial-transitealth prior to burial, cram.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  /PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO Underlying cause last.  (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II of Item 18.)  DUE TO  PREFORMED?  YES NOW  20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  INTERVAL BETWEEN ONSET AND DEATH ONSE
	HYSI he h this letac Dep	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)  Hour a.m.
•	TO HOSPITAL OR ATTENDING P Page 4 may be retained by t TO FUNERAL DIRECTOR: After director, page 3 should be of should be filed with the State	21. I certify that (i) (this hospital) attended the deceased from 3 - 5, 19.57, to 4 - 16, that (i) (we) last saw the deceased alive on 4 - 19.6, and that death occurred at M, from the causes and on the date stated above.  22a. SIGNATURE  ATTENDING MED. DIRECTOR STAFF PHYS. DATE SIGNED  22b. DATE SIGNED  22c. PHYSICIANY NAME (APPE) ROBERT AD TERM 22d. ADDRESS AD TERM 22d. ADD
	FO HOSPITAL Page 4 may O FUNERAL director, pa should be fil	NAME CURSE, ROBERT NO. DEEB 5. S. HOSPITAL - SIKESVILLE MD.  23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 1 23d. LOCATION (City, town or county) (State)
	<b>5</b> 5 4 6	REMOVAL (Specify)  Burial 4/19/66 Loudon Park Cemetery Baltimore, Maryland  ADDRESS 1258. REG'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE
	VR A15 (4)	Wm. Cook-Brooks Inc. 1217 St. Paul St. DAPR 19 1966 fcliarles Judge.
	20M 1/65	



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05124 CERTIFICATE OF DEATH death. requires that the death certificate be executed within 24 hours after death physician and campletely filled in by the funeral en please remove taxon papers. Pages I and aval, and in any event, within 72 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY **b** COUNTY Balto. City Carroll Maryland MARYLAND b CITY OR TOWN (if outside corporate I mits, write RURAL and give nearest town)
Sykesville c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 15 Baltimore 42 yrs.5 mos.25 dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? (unknown) Springfield State Hospital YES NO X 3 NAME OF Middle 4 DATE East Manth Day DECEASED APRIL 6 19 66 (Type or print) LENA (MADELINE) MANNING none) DEATH IF UNDER 1 YEAR 6 COLOR OR RACE 8 DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS 7. MARRIED **NEVER MARRIED** White last birthday) Months Days Haurs Female WIDOWED X DIVORCED 11-11-92 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY Maryland
14 MOTHER'S MAIDEN NAME U.S.A. Housewife
13 FATHER'S NAME (Unknown) (Unknown) IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, na, ar unknown) (If yes give war ar dates of service) Records, Springfield State Hospital None No INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one couse per ime for (o), (b), opd (c)) signed by the burial-transit p PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician DUE TO Conditions, if any, which gave (b) rise to immediate cause (a), **DUE TO** stating the underlying couse tar use as the t f Health priar to b TO FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) Schizophrenic reaction, paranoid type. YES X NO [ 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20g ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER page 3 shauld be detache be filed with the State Dept. 20d INJURY OCCURRED (City or town) TIME OF INJURY Month, Day, Year 20e PLACE OF INJURY (Home, form, (County) (State) Not While factory, street, affice bldg., etc.) at wark at work 21. I certify that (1) (this haspital) attended the deceased fram 10-11 1966, that (We) last 19_66, and that death accurred at 12:3M, Fam couses and an the date stated above saw the deceased alive on 4-6 22b. DATE SIGNED 22o. SIGNATURE **ATTENDING** 4-6-66 uman M.D. PHYS DIRECTOR 22d, ADDRESS 22c. PHYSICIAN'S Ilse Kamm, M.D. Sykesville, Maryland NAME (Type) directar, should b 230 BURIAL, CREMATION, DEMOYAL (Specify) 23d LOCATION (City or Town)
Baltimore, Maryland 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (Stote) (County) 4-11-1966 (armel 250 REC'D BY REGISTRAR 25b. REGISTRAR S SIGNATURE 24 FUNERAL DIRECTOR ADDRESS VR A15 (4) 190107 Eastern Ave. 1966 Lilly & Zeiler Inc .. 20 M 1/66

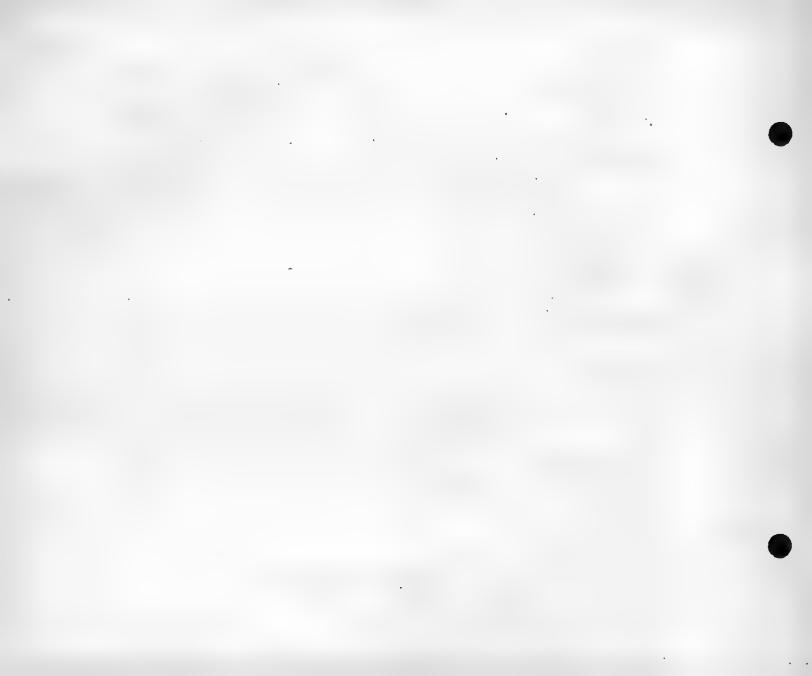


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 deat hours after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY Carroll anti-completely filled in by the if remove carbon papers. Tages 1 any event, within 72 hours after Maryland MARYLAND Anne Arunde. D. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH DF STAY IN 1b Sykesville 3yrs.7mos.17dys Linthicum Heights d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS 202 Homewood Road ND X Springfield State Hospital YES executed within NAME OF DATE Month Middle Last 4. DECEASED BLANCHE CLARICE MASSEY APRIL 14 19 66 (Type or print) DEATH 5. SEX AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) | Months | Days Female White 11-11-02 WIDOWED J DIVDRCED 1Da. USUAL OCCUPATION (Give kind of work done | 1Db. KIND OF BUSINESS OR physician n please val, and in = 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT death certificate be during most of working life, even if retired) COUNTRY? Waitress/housekeeper Virginia U.S.A. attending physermit. Then ple 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Roland Kelly Adeline Shea 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unkown) | (If yes give war or dates of service) 16. SOCIAL SECURITY NO. ed by the attent transit permit. , cremation, or ri 17. INFORMANT Address No Records, Springfield State Hospital (none) 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH signed by nurial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). PHYSICIAM: The law requires that till the hospital or attending physician. Coronary occlusion minutes been Signal-tre Arteriosclerotic coronary disease years Conditions, if any, which gave rise to immediate as the t DUE TO cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) certificate has the street of Health part. 19. WAS AUTDPSY Chronic Brain Syndrome associated with presentle brain disease, without qualifying phrase 2Da. ACCIDENT WAS UNDERLYING TO 2DD. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) PERFORMED? ND X 2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED | 2De. PLACE DF INJURY (Home, farm, 2Df. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. Not While While at work at work OR ATTENDIN be retained b DIRECTOR: A age 3 should lied with the 5 1962 to 4-14 О 8-27 1966, that (#) (we) last 21. I certify that-(+) (this hospital) attended the deceased from_ 19.66, and that death occurred at 9:50% from the causes and on the date stated above. saw the deceased alive on 4-14 22a. SIGNATURE 22b. DATE SIGNED April 14. page ATTENDING PHYS. MED. Page 4 may b PHYSICIAN'S 22d. ADDRESS director, p should be 1 NAME (Type) Ilse Kamm. M.D. Sykesville. Maryland NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) BURIAL, CREMATION, Delmar, Del. 4-16-66 St Stephens FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 2DM 1/65



,		1 1.5	M	Division of STATISTICA	MAKYLAND STATE DEP 11 RESEARCH AND RECORDS, 301			01
6		101	기	05126	CERTIFICATE	OF DEATH		05125
and the same	eoth	ond 2	1	PLACE OF DEATH			re deceased lived, if institution. Resident	te before odmission)
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	hou	s. Po		d NAME OF HOSPITAL OR INSTITUTION (If not in	hospitol, give street oddress)	d. STREET ADDRESS	rung (NH)	e IS RESIDENCE
	า 24	filled in papers. Ithin 72 h		Carroll Count	- General Hope	Tot Sollers	a Frailer Court	YES NO
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	ote	E a lo		DEWELL WAS IN	merlege	Killann	my Fa - 11	·S-Q.
	Ę,	ending physical Theorem or removal,		3 FATHER'S NAME	in Slaven	14. ( MOTHER'S MAIDEN NAM	Blant	
	th ce	e Tea	-	S WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, ar unknown) (1 yes guy war ar dates of ser	.6 SOCIAL SECURITY NO 17 IN	FORMANT	Address	ntesting 2
	dea	ottending p permit. The ion, or remo		1965, no drenknown) (1 yes gaye word a dotes of ser	205-12-4228 7/1	to Thelma	S. mc Elwa	in RERIA
	t the			8 CAUSE OF DEATH (Enter only one couse p PART I. DEATH WAS CAUSED BY.	er line for (a), (b), and (c))			INTERVAL BETWEEN ONSET AND DEATH
	tha ion.	signed by the buriol-tronsit burial, cremat		IMMEDIATE CAUSE (o)_	y to accepting the	·Cuo		
	equires the	signed the buriol-tr		Conditions, if any, which gave (b)_ rise to immediate couse (a),				
	PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.			stating the underlying couse	Comming 8	with liver		
	s law tendi	s be os tl prior	1.	PART II. OTHER SIGNIFICANT CONDITIONS CONTE	RIBUTING TO DEATH BUT NOT RELATED TO TH	E TERMINAL DISEASE CONDIT	ION GIVEN IN PART 1(a)	19 WAS AUTOPSY PERFORMED?
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	CIAN	for for the	HOTTESTOTES	20o. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEATH	205. DESCRIBE HOW INJURY OCCURRED (E	nter nature of injury in Port	I or Port II of item 18.)	
	HYSI hoso	s cert	15	(IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year	20d INJURY OCCURRED 20e, PLACE	OF INJURY (Home, form,	20f. (City or town) (Cou	unity) (State)
	5 P	de De C	10000	Hour o.m.		ry, street, office bldg., etc.)		, ,
	N A	Afte d be e Sto		21 I certify that (I) (this hospita	il) attended the deceased fram 🗷	no 30, 19(	16, 10 april 2, 196	ر , thot (۱) (we) last
	TTE	TOR Hood		saw the deceased alive an Cy-	19.66, and that		M, from causes and on the	ne dote stated above. ATE SIGNED
	OR ATTENDING be retained by the	IREC 3 s d wi		Jahren S. Ha	M.D.		D. STAFF PHYS.	4/2/66
	TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Pone 4 may be retained by the hospital or ottending	for Euneral Directors, After this certificate has been director, page 3 should be detoched for use os the should be filed with the State Dept. of Health prior to	/	22c. PHYSKIAN'S NAME (Type) JOHN S	. HARSHEY NO.	22d, ADDRESS	St. Westwent	and my
	HOSF	FUNE	1	30 BURIAL, CREMATION, 23b. DATE THEREO	F. 23c MAME OF CEMETERY OR CO	REMATORY B	-93d LOCATION (City or Town)	(County) (Stote)
	5 %	<b>5</b> 9 4	4	24 FUNERAL DIRECTOR	ADDRESS AT LALE	2So REC'D BY	REGISTRAR 25b. REGISTRARS SI	IGNATURE
		VR A15 (4) , 20 M 1/66		L. S. mucro. D.	brestmiste	SMA DAPR G	1966 Ochanle	0.455
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05127 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death by the funeral Pages 1 and 2 death 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) I PLACE OF DEATH o. COUNTY **b.** COUNTY o. STATE Carroll Marvland **MARYLAND** attending physician and campletely filled in by the fur permit. Then please remove carbon papers. Pages 1 an, or remaval, and many event, within 72 haurs after b CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town)

Rural—Sykesville c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) Baltimore 6mo. 11days d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 2806 Roselawn Avenue Springfield State Hospital NO X 4 DATE 3 NAME OF Middle Day Year DECEASED (Type or print) **OF** 4 19 66 12 Laura Virginia Mettee DEATH YEAR IF UNDER 24 HRS DATE OF BIRTH IF LINDER 1 S SEX 6 COLOR OR RACE 7 MARRIED **NEVER MARRIED** AGE (In years burthdoy) Months Days 03/12/80 WIDOWED white female 10a LSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of wark no life, even if retired) COUNTRY? INDUSTRY USA Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Mary Elizabeth Main Richard Tydings 1S WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) (If yes give war ar dates of service) 17. INFORMANT Address 16. SOCIAL SECURITY NO Springfield Hospital records-Sykesville 218-46-2460 burial, crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) burial-transit ONSET AND DEATH PART I DEATH WAS CAUSED BY-Bronchopnemmonia signed by 1 IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital or attending physician. DUE TO Uremia days Conditions, if any, which gove (b) rise ta immediate cause (a), DUE TO for use as the l fHealth priar tab stating the underlying cause this certificate has been detached for use as the e Dept. af Health priar tall Arteriosclerotic cardiovascular disease years PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DUSEASE CONDITION GIVEN IN PART 1(0)

Chronic brain syndrome with senile brain disease without WAS AUTOPSY PERFORMED? YES T NO T qualifying phrase. 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of item 18.) 20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) be detached State Dept. o 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year Hour a.m. Not While factary, street, office bldg., etc.) at work O FUNERAL DIRECTOR: After at work 19 65 to 1966 , that (\$ (we) last 2). I certify that (\$\\$(this hospital)\ attended the deceased from 10/1/, 19.65, to 4/12/, 1966, that (\$\\$(we)\ last saw the deceased above an 4/12/ 19.66, and that death accurred at 8:30M, from causes and an the date stated above. 3 shauld to with the S saw the deceased alive an. 220. SIGNATURE 22b. DATE SIGNED ATTENDING 4/13/66 K M.D. PHYS DIRECTOR PHYS directar, page 3 shauld be filed ed Springfield State Hospital Sykesville, Maryland 22d. ADDRESS 22c PHYSICIAN'S Reeves, M. D. Edmes NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF 23d. LOCATION (City or Town) (State) 230. BURIAL CREMATION (County) Baltimore, Maryland 16.1966 Oaklawn Cemetery Cliarly S VR A15 (4) 20 M 1/66 EMHOR Loll Rark Heights Ave.

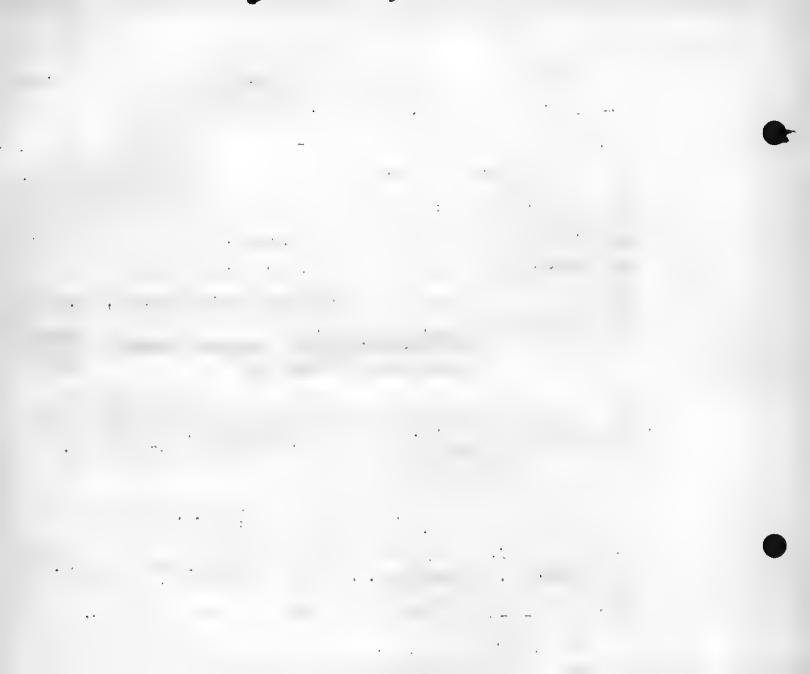
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH uneral and 2 hours after death, PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY 110 F Carrell the 1 es 1 Pages 1 urs after MARYLAND b. CITY OR TOWN (if outside corporate limits. C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) þ Rural and give nearest town) Cumberland 9Day 2, wbon papers. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled d. STREET ADDRESS IS RESIDENCE 24 Springfield State Hospital ON A FARM? 12 Harrisen Street NO A YES executed within mpletely NAME OF Eirst , Middle DATE Month Last Year John DECEASED Morrissey Nicholas OF DEATH 30 19 66 (Type or print) 5. SEX 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIED NEVER MARRIED (aptablethday) Months Male Days Hours sician and lease reme and in any WIDOWED [ DIVORCED [ 1Da. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fereign country) 12. CITIZEN OF WHAT The law requires that the death certificate be during most of working life, even if retired) COUNTRY? U.S.A. attending physic ermit. Then plea m, or removal, an Cumberland Ret. Juner 13. FATHER'S NAME Antique 8 DUSLARSS 14. MOTHER'S MAIDEN NAME Michael errissey Innie Farleng ed by the attend transit permit. cramation, or re 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, Togunkown) (If See in Security of dates of service) 16. SOCIAL SECURITY NO. | 17. INFORMANT Address 220-10-7120 Springfield Hospital Records CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). ] INTERVAL BETWEEN has been signed by te as the burial-transit CONSET AND DEATH PART I. DEATH WAS CAUSED BY: O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that ti Page 4 may be retained by the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate **DUE TO** cause (a), stating the underlying cause last. has CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use Health p WAS AUTOPSY PERFORMED? certificate Chronic Brain Syndrone of Unknown Cause YES NO DO 20a. ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) detached for the details of the deta this MEDICAL 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Hour a.m. After Id be d While Not While 19 at work p.m. at work FUNERAL DIRECTOR: At lirector, page 3 should I hould be filed with the S 66 that M (we) last 21. I certify that of (this hospite) at anded the deceased from saw the deceased alive or and that death occurred at. M. from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED **ATTENDING** ( -> Springfield PHYS. PHYSICIAN'S NAME (Type) te Rosoital director, p should be 1 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) REMOVAL (Specify) 2 Maryland Burial 166 Peter & Paul Com Cumberland 24. FUNERAL DIRECTOR ADDRESS REC'D BY REGISTRAR 25b. KEGISTRAR'S SIGNATURE H. Wayne George Cumberland, Maryland VR A15 (4) 20M 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 05129CERTIFICATE OF DEATH hours after death. PLACE DF DEATH USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. COUNTY b. COUNTY Carroll Maryland by the Pages 1 ars after Washington MARYLAND b. CITY DR TOWN (if outside corporate limits, c. LENCTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Rural -- Sykesville lyr. 9days Gapland d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital YES ! ND within bon etel Middle Month 1act DATE Year DECEASED DF DEATH event, Beulah Virginia (Type or print) Moss L 19 66 law requires that the death certificate be executed 5. SEX 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED and bon DATE OF BIRTH ACE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS last birthday) | Months | Days Hours ! female white WIDOWED TE 10/21/92 DIVORCED TO 1Da. USUAL OCCUPATION (Clye kind of work done | 1Db. KIND DF BUSINESS OR during most of working life, even if retired) INDUSTRY = 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT by the attending physician nsit permit. Then please remation, or removal, and in COUNTRY? Housewife Maryland USA 13. FATHER'S NAME MOTHER'S MAIDEN NAME James Cochran Ida Reeder 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) [(If yes give war or dates of service)] 16. SOCIAL SECURITY NO. 17. INFORMANT Address Springfield Hospital records, Sykesville none 18. CAUSE OF DEATH [ Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN signed by urial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). the hospital or attending physician. months been signed the burial-tr Heart DISCASE Arterioscleratic DUE TO Conditions, If any, which Bronchowne Umo gave rise to immediate DUE TO cause (a), stating the as th underlying cause last. PART II. O THER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

Chronic brain syndrome with circulatory disturbance other than cerebral arteriosclerosis (arteriosclerosis & hypertensive 2Da. ACCIDENT WAS UNDERLYING OF DESCRIBE HOW INVIDED (Enternature of Divry in Part 1 of Part 1 of Part (IF EITHER, NOTIFY MEDICAL EXAMINER) WAS AUTOPSY for use Health PERFORMED? YES TO NO T 200 ASSCRIBE HOW INJURY OCCURRED LEnterysture of Injury in Part | or Part | detached f 20c. TIME DF INJURY Month, Day, Year 2Dd. INJURY OCCURRED | 200. PLACE OF INJURY (Home, farm, (State) 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. Not While at work p.m. at work 19 66 that ( (we) last P should ith the 21. I certify that # (this hospital) attended the deceased from 4/5/ 19 66 ... and that death occurred at 2:004. from the causes and on the date stated above. DIRECTOR age 3 should be sided with t saw the deceased alive on. 22a. SICNATURE 22b. DATE SICNED O HOSPITAL OR Page 4 may be page ATTENDING DIRECTOR M.D. o FUNERAL director, pa should be fil PHYSICIAN'S 22c. ADDRESS Springfield State Hospital 22d. NAME (Type) Buvukunsal Sykesville, Maryland BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Soecify) 23d. LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY (State) Burial 7- 66 Locust Grove Cemetery Locust Grove, Md. REC'D BY REGISTRAR 25b. REGISTRAR'S SICNATURE FUNERAL DIRECTOR **ADDRESS** 25a. VR A15 (4) band 20M 1/65



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE I, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution, Residence before edmission) a. COUNTY **b.** COUNTY Carroll Maryland MARYLAND b. CITY OR TOWN (if outside corporate limits c. CITY OR TOWN (If oulside corporete limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b write RURAL and give nearest town) Rural Middleburg 4 teeks
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) Rural Taneytown d STREET ADDRESS IS RESIDENCE ON A FARM? YES Y NO Brookfield Manor Nursing Home NAME OF Middle 4. DATE Month Year DECEASED OF [Type or print] DEATH 1966 Grace Motter Apri 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 8. DATE OF BIRTH last birthday) Months Days Hours WIDOWED DIVORCED Sept. 4, 1882 Female White IDs. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY II BIRTHP, ACE (County & Stele, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) U.S.A. <u>Housewife</u> Own home Maryland 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME anding plea Thomas Baker Elizabeth Shriner 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO | 17 INFORMANT Address (Yes, no, or unknwn) | (Ifyesgive wer or detes of service) Mr. Clarence J. Motter, Taneytown, Md. 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY: 2-days IMMEDIATE CAUSE (e) embral athers se lusses and thrombos is DUE TO Conditions, if any, which (b) peve rise lo immediale cause DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO 20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Pert I or Part II of Iem 18 ) 200. ACCIDENT WAS UNDERLYING [7] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e, TIME OF INJURY 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, ferm, 20f. (City or lown) (County) (Stete) Month, Day, Year factory, street, office bldg., etc.) White Not While Hour e.m. at work et work D. M. 21. I certify that (I) (this hospital) attended the deceased from ....3. ., 19. ..., that (I) (we) last 19 10 .....19......., and that death occurred at 1/32 M, from the causes and on the date stated above saw the deceased alive on. 22ar SIGNATURE ATTENDING SEGNED DIRECTOR PHYS. PHYS 22c. PHYSICIAN'S 22d, ADDRESS NAME (Mpe) Union Bridge, Maryland .H.Caricofe 23a. BURIAL, CREMATION. | 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Slate) REMOVAL (Specify) る音品 5. 1966 Mt. View Cemetery Emmitsburg, Maryland Burial 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25. REC'D BY REGISTRAR 256. REGISTRAR'S. VR A15 14 C.O.Fuss & Son, TaneytownmMd DAPR

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05131 CERTIFICATE OF DEATH 24 hours after death. funeral s 1 and 2 ter death 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY b. COUNTY Carroll Maryland on papers. Pages 1 within 72 hours after MARYLAND by the for b CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rural -- Sykesville 10y. 11m. 6d. Baltimore filled in I d. STREET ADDRESS e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 311 Cathedral Street Springfield State Hospital YES NO 3 requires that the death certificate be executed within First Middle NAME OF Lost 4 DATE Month Doy Year On completely i DECEASED OF 4 19 66 Margaret Dolores Murray 24 ment, (Type or print) DEATH IF UNDER 24 HRS. SEX DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR 6 COLOR OR RACE 7, MARRIED NEVER MARRIED гегроуе birthdoy) Hours 6/15/82 white duy female DIVORCED WIDOWFD 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12. CITIZEN OF WHAT 10o USUAL OCCUPATION (Give kind of work done and in COUNTRY? ease during most of work ng life, even if retired)
Registered nurse INDUSTRY ottending physician sermit. Then please Maryland USA 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME burial, cremation, or removal, Anna Cecilia Ward Daniel A. L. Murray 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dates of service) Springfield Hospital records -- Sykesville unknown INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit p MARTHAN DEATH PART 1. DEATH WAS CAUSED BY. Cardiac failure IMMEDIATE CAUSE (o) DUE TO Carcinoma breast metastasis Years Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying couse Page 4 may be retained by the hospital or ottending to FUNERAL DIRECTOR: After this certificate hos been signification, page 3 should be detached for use as the tabhould be filled with the State Dept. of Heolth prior to be 19 WAS AUTOPSY PERFORMED? PART HI. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0).

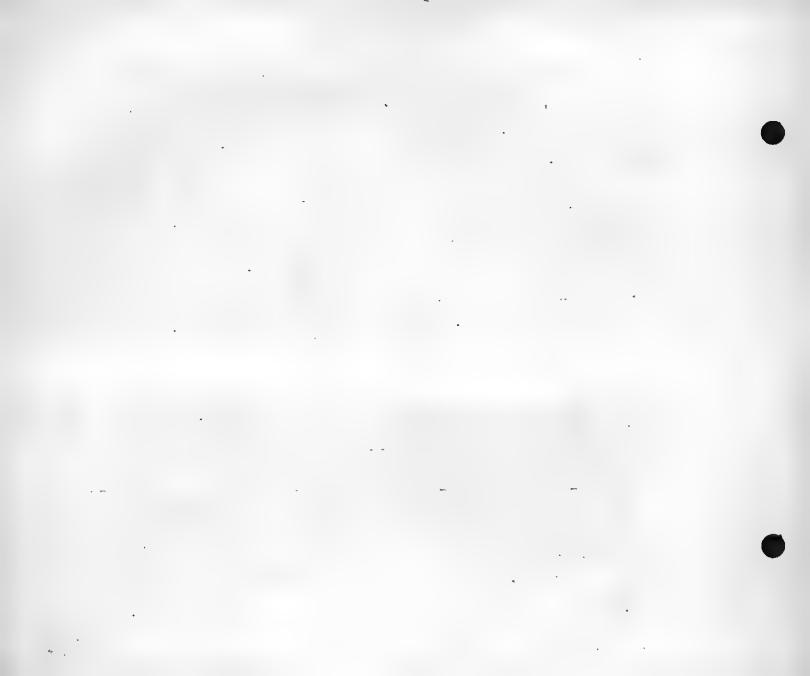
Chronic brain syndrome associated with cirquiatory disturbance, YES 🗀 NO arteriosclerosis with psychotic reaction. 205. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) 20o. ACC DENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED Hour om factory, street, office bldg , etc.) Not While 19 of work at work 19 55, to m4/24/, 19 66 that A (we) last 21 I certify that (*) (this haspital), attended the deceased from 19 66 and that death accurred at 1:45 M, fram causes and on the date stated above. saw the deceased alive an 22b. DATE SIGNED 220 SIGNATURE **ATTENDING** 4/24/66 DIRECTOR M.D. PHYS Springfield State Hospital 22d ADDRESS 22c. PHYSIGAN'S Buyukunsal, NAME (Type) Sykesville, Maryland DATE THEREOI 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 230 BURIAL CREMATION (County) REMOVAL (Specify) MORP DIA 250. REC'D BY REGISTRAR REGISTRAR'S SIGNATUR FUNERAL DIRECTOR 2Sb. VR A15 (4) 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death; hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY Pages 1 Carroll a. STATE b. COUNTY MARYLAND Maryland Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b hours a 11mRural) Sykesville .5 Hagerstown 21.740 pers. 72 hd d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE filled d. STREET ADDRESS Springfield State Hospital ON A FARM? Wilson BoulevaraYES NO ... within 3. NAME OF DATE Month First Middle Last Day Elne **OECEASED** 1966 comple ve carb event. MIRE (Type or print) DEATH CSTO, executed AGE (In years | IF UNDER 1 YEAR HE UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH гетоуе 8 ast birthday) Months | Days 10-3-1881 any and WIDOWED -DIVORCED | male 10a. USUAL OCCUPATION (Give kind of work done | 12. CITIZEN OF WHAT .= 10b. KINO OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) ician lease and ir death certificate be during most of working life, even if retired) INDUSTRY Cearross **COUNTRY?** ush USA d by the attending physicansit permit. Then plecentation, or removal, a Farmer Maryland MOTHER'S MAIDEN NAME 13. FATHER'S NAME William Myers Mary A. Sprankle 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) ((If yes give war or dates of service) none 7-12-1840 Hospital Records INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PHYSICIAN: The law requires that the been signed by the burial-transit or to burial, crema ONSET AND CEATH PART I. DEATH WAS CAUSED BY: attending physician. Bronchopneumonia daus IMMEDIATE CAUSE (a) I III DUE TO Cenditions, If any, which gave rise to immediate DUE TO cause (a), stating the prior 1 underlying cause tast. has 38 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY for use Health PERFORMEO? certificate Chronic brain syndrome associated with cerebral arteriosclerosis No 🕝 TITH DSYCHOTIC TEACTION

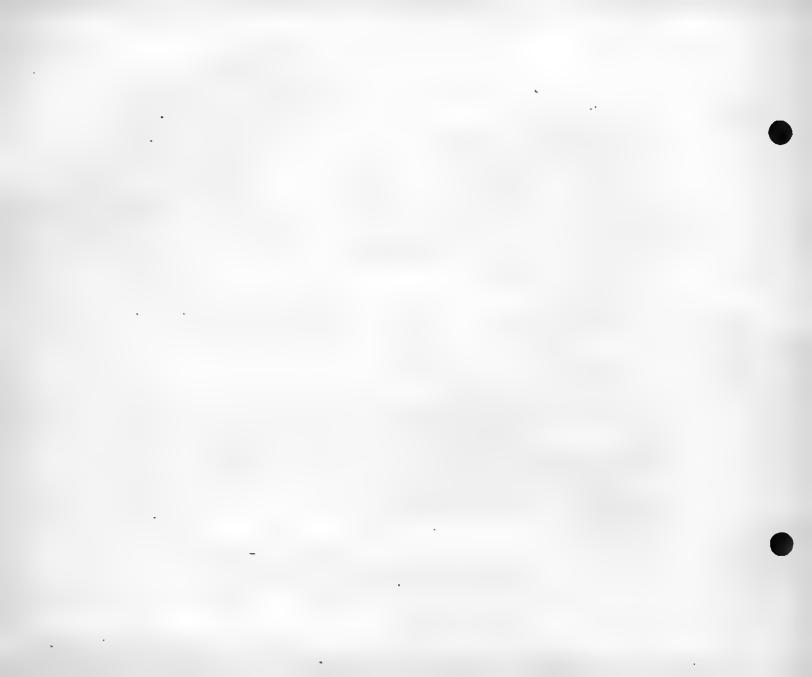
20a. ACCIDENT WAS UNDERLYING | ZOB. OESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)

OR CONTRIBUTING | CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) this cerum detached fo 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, (County) (State) 20c. TIME OF INJURY Month, Cay, Year factory, street, office bldg., etc.) Hour a.m. While at work at work p.m. retained 3 should with the v 5-20-65. to. 4-28 1966_, that **(()** (we) last 21. I certify that (1) (this hospital) attended the deceased from... DIRECTOR: and that death occurred at The from the causes and on the date stated above. saw the deceased alive on. 22b. DATE SIGNED 22a. SIGNATURE page ATTENDING STAFF M.D. DIRECTOR PHYS. O HOSPITAL PHYSICIAN'S 22c. 22d. ADDRESS FUNERAL director, should be be NAME (Type) Sam P. Wise Springfield State Hospital 23a. BURIAL, CREMATION, 23b. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) REMOVAL (Specify) roadfording Dunkard . е uria 24. FUNERAL DIRECTOR ADDRESS A15 (4)



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05#33 05132 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. attending physicion and completely filled in by the funeral permit. Then pleases combon papers. Pages I and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission, a. COUNTY o. STATE b. COUNTY MARYLAND c. LENGTH OF STAY IN 1b) b CITY OR TOWN (If outside carparate I mits. outside comparate limits, write RURAL a NAME OF HOSP TAL OR INSTITUTION (If nat in haspital, give street address)" d. STREET ADDRESS IS RESIDENCE ON A FARM? within 72 NO [ 3 NAME OF First Middle DATE Manth Day DECEASED OF DEATH 19 66 (Type or print) AGE (In years lost orthogy) IF JNDER 1 YEAR IF UNDER 24 HRS S SEX 6 COLOR OR 7. MARRIED NEVER MARRIED DATE OF BIRTH Months Doys Hours DIVORCED WIDOWED 10a LSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY ?-13. FATHERS NAME 14. MOTHER'S MAIDEN NAME IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address # (Yes, no or unknown) ((If yes give war or dates of service) INTERVAL BETW 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) buriol-tronsit PART I. DEATH WAS CAUSED BY APHEAGMATIC IMMEDIATE CAUSE (a). DUE TO RTERIOSCLEROTIC Conditions, if only, which gove rise to immediate cause (a). DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been os the last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? ELLITUS NO BRETES YES the hospitol or for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port II of item 18.) 20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, (City or fown) (County) (Stote) Haur o.m. foctory, street, office bldg., etc.) Not While nt work , 1966, to 21. I certify that (1) (this haspital) attended the deceased fram. 4/28 , 1966, that (1) (we) last and that death accurred at 433M, from causes and an the date stated above. 4/28 1966 saw the deceased alive an 220 SHGNAJURE_ DATE SIGNED ATTENDING MED. DIRECTOR Lucen M.D. PHYS PHYS 22d ADDRESS 22 PHYSICIAN'S NAME (Type) director, should b 23b. DATE THEREOF NAME OF CEMETERY OR GREMATORY 23d. LOCATION (City or Town) BURIAL, CREMATION, (County) (Stote) REMOVAL (Specify) FUNERAL DIRECTOR 250 REC D BY REGISTRAR VR A15 (4) 20 M 1/66 Clian

MARYLAND STATE DEPARTMENT OF HEALTH



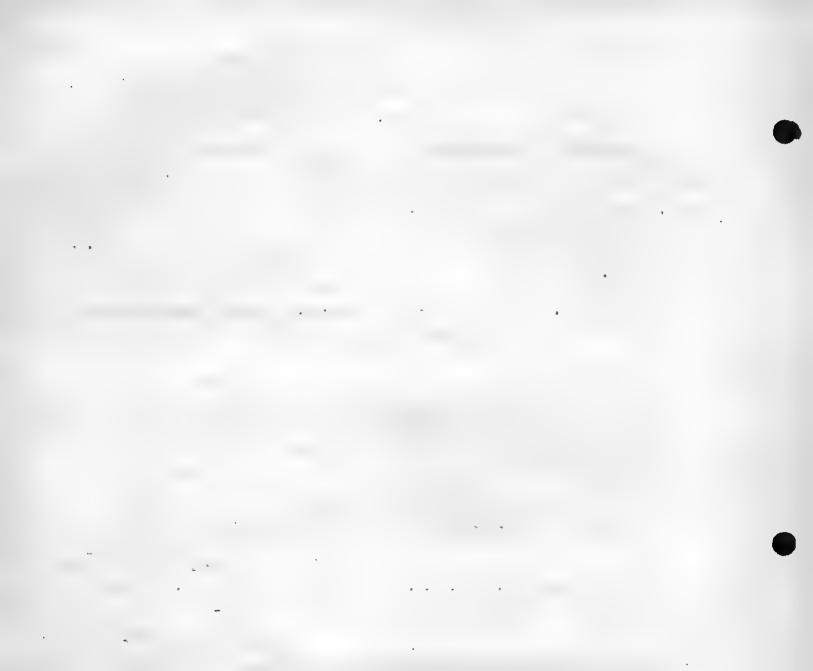
	CERTIFICATE OF DEATH	05133
	2. USUAL RESIDENCE (Whate daceased lived, County  MARYLAND  2. USUAL RESIDENCE (Whate daceased lived, b. COL  Maryland  Maryland  Description  Maryland  Maryland  Description  Maryland  Description  Maryland  Maryland  Description  Maryland  Maryland  Description  Maryland  Maryland  Description  Maryland  Maryland	
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give neerest town)  c. LENGTH OF STAY IN 1b  c. CITY OR TOWN (if outside corporate limits, wr	ile RURAL end give neerest town)
-	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street eddress) d. STREET ADDRESS	
	Who Abh 're' North Hold Miller's Conv. 2109 Harover Street	e, is réside On a fa Yes No
3	NAME OF First Middle Deceased 4. DATE Mor	
5.	Thomas Brewster. Panaler Death Apr.	
<b>3.</b> 3	Mala IIII to Never Markied Never Markied III A Co. 100 III III III III III III III III III	/s IF UNDER 1 YEAR IF UNDER 24 H Months Deys Hours Mi
1De	. USUAL OCCUPATION (Giva kind of work   10b. KIND OF BUSINESS OR INDUSTRY   11 BIRTHPLACE (County & State, or foreign country	y) 12. CITIZEN OF WHAT COUN
	Cet. Hist. Station Master Terrinal Co. Vashington, D. C.	U.S.A
	13. FATHER'S NAME	
	Thomas B. Penicks.  15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO. 17. INFORMANT	
	(Yes, no, or unkawn) (Ifyes g vewer or detes of service) Yes David C. Penicks Royan Ci	to walled.
	is. CAUSE OF BEATH (Enter only one cause per line for (e), (b), end (c).	INTERVAL BETWEE
	PART I DEATH WAS CAUSED BY: Massive caronary thrombosis	April 8,
	4 3 0 / DUE TO	1966
	Conditions, if eny, which gove rise to immediate cause  (b) Arteriosclerosis, generalized.	Through April 17.
	(e), stating the underlying DUE TO (c)	1966
NO	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G	IVEN IN PART 1(a) 19. WAS AUTOI
	2De. ACCIDENT WAS UNDERLYING : 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter neture of injury in Part   or Pert II of IIem 18.)	YES NO
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G  2De. ACCIDENT WAS UNDERLYING   2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nerture of injury in Part I or Part II of Ilem 18.)  (If EITHER, NOTIFY MEDICAL EXAMINER)	
ľ	20c. TIME OF INJURY Month, Dey, Yeer 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) While Not While Sectory, street, office bldg., etc.)	(County) (State
MED	Hour a.m. While Not While fectory, street, office bldg., etc.) p.m. 19 at work et work	
	21. I certify that (I) (this hospital) attended the deceased from April 8,, 1966, to April	
	saw the deceased alive on April 17.,19.66, and that death occurred at 6 P. M. from the causes	and on the date stated abo
		April 18, 1966
	NAME (Type)	
	howard E. Hall, M.D. Sykesville, Maryland	
	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, N. REMOVAL (Specify)	, ,
	Creration 19 April 1966 9t. Lincoln Cemetery Prince Goods. 24 FUNERAL DIRECTOR'S SIGNATURE 1968 84 ADDRESS Orgin August 250. REC'D BY REGISTRAR 256. R	GEOTGE (O. Md.
	The 2 E. Pumphrey, 2 ic. Silver Spring, Md. APR 2 1 1966 10	6 . 6.



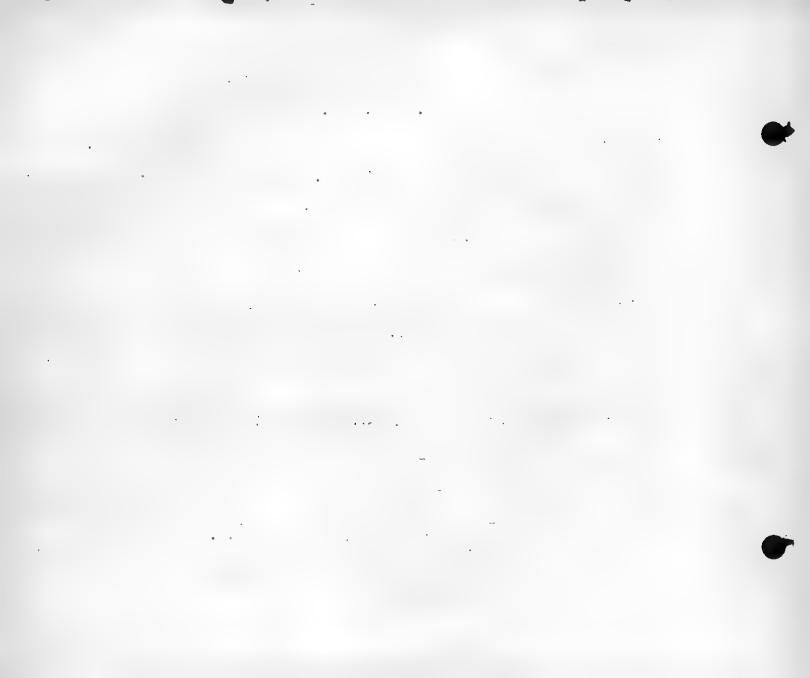
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05134 05135 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs ofter death puo deoth 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) physicion and completely filled in by the funeral en please remove carbon popers. Pages 1 and oval, and in anywayay, within 72 hours after deat PLACE OF DEATH o. COUNTY Carroll o. STATE Maryland b. COUNTY Baltimore City MARYLAND c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town)
Sykesville Baltimore 25 dvs. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e (S RESIDENCE ON A FARM? No fixed address Springfield State Hospital NO X YES 24 1 34 Kast 3 NAME OF Middle 4. DATE Month Year DECEASED SHERMAN HENRY PHEFFER 16 19 66 APRIL (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. DATE OF BIRTH 9. AGE (In years SEX 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** 50st birthday) Months Doys Hours Negro Sep . DIVORCED 7-5-11 Mala director, page 3 should be detached for use as the burial-tronsit permit Then please remo should be filed with the Stote Dept. of Heolth prior ta buriol, crematian, or removal, ond in any 12. CITIZEN OF WHAT IGo, USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) CDUNTRY? during most of working life, even if refired)

Laborer INDUSTRY Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Unk. Anne Harris WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) 218-05-5888 Records, Springfield State Hospital Unk. Yes INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per time for (o), (b), and (c) ) signed by the burial-tronsit p ONSET AND DEATH PART I, DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) Bilateral bronchopneumonia Page 4 may be retained by the hospital or ottending physician. DUE TO Conditions, if any, which gave (b) rise to immediate couse (a), DUE TO stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO K 20d ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME DF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) Not While of work 19 1-16-66, 19 , that (I) (we) last 21. I certify that (!) (this haspital) attended the deceased from 3-21-66 sow the deceased alive an 11-16-66 and that death occurred at M. from causes and an the date stated obove. 22b. DATE SIGNED 22o, SIGNATURE ATTENDING MED. DIRECTOR STAFF 4-19-66 X M.D. 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz. M.D Sykesville. Maryland 23C. NAME OF CEMETERY DR CREMATORY. 23d. LOCATION (City or Town) 23g BURLAL CREMATION, 23b. DATE THERED F (County) (Stote) REMDVAV (Specify) ANATIBA 2Sb. REGISTRAR'S SIGNATI 2So. REC'D BY REGISTRAR FUNERAL DIRECTOR

MARYLAND STATE DEPARTMENT OF HEALTH

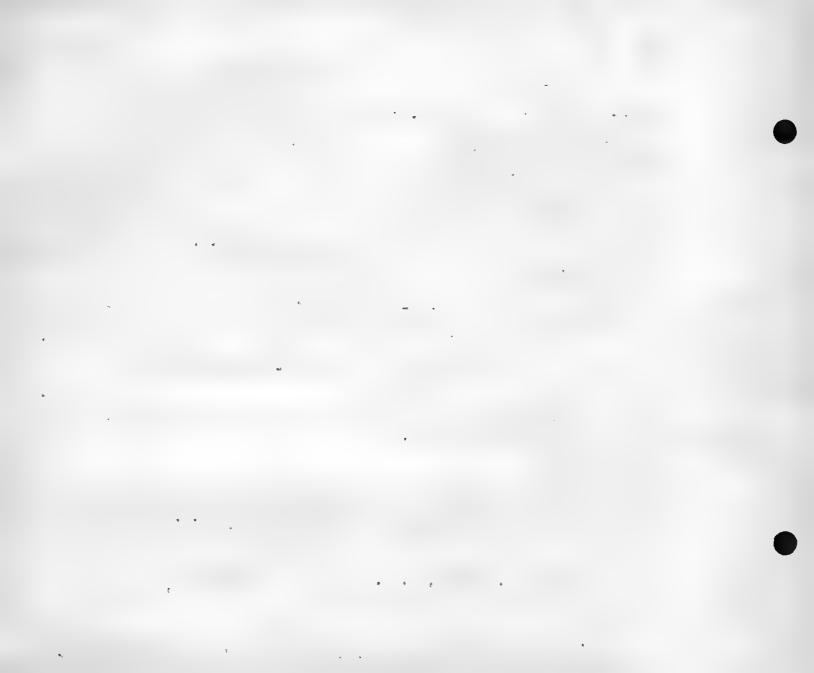


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 hours after death, and PLACE DF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) Pages 1 aften d b. COUNTY Carroll Maryland Montgomery MARYLAND CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENCTH OF STAY IN 1b (Rural) Sykesville 9yr. llmo. 4da Silver Spring = d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET AOORESS e. IS RESIDENCE ON A FARM? Springfield State Hospital YES NO S Silver Spring le l 3. NAME OF Middle 4. DATE Month Last DECEASED (Type or print) Herbert DEATH William 19 66 Priestley 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED AGE (In years | IF UNDER 1 YEAR IIF UNDER 24 HRS 5. SFX remove 8. OATE OF BIRTH last birthday) Months | Days in any and WIDOWED [ DIVORCED [ male white 9-8-85 80 уга. physician an please reval, and in 10a. USUAL OCCUPATION (Cive kind of work done | 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) death certificate be during most of working life, even if retired) COUNTRY? Carpenter Maryland
MOTHER'S MAIDEN NAME TISA 13. FATHER'S NAME attending physical in the property of the prop William Priestley Elizabeth Penophy 15. WAS DECEASED EVER IN ILS. ARMED FORCES? ed by the attend transit permit. cremation, or re 16. SOCIAL SECURITYNO, | 17. INFORMANT (Yes, no, or unkown) | (If yes give war or dates of service) unknown 579-07-1409 Hospital Records burial transit the 18. CAUSE OF DEATH [ Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Arteriosclerotic heart disease vears 10000 DUE TO Generalized arteriosclerosis years Conditions, If any, which gave rise to immediate 音音 DUE TO cause (a), stating the as the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) WAS AUTOPSY for use Realth PERFORMED? Chronic brain syndrome, associated with psychotic reaction certificate YES TY NO F 20a. ACCIDENT WAS UNDERLYING TO BE CONTRIBUTING CAUSE OF OFATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ATTENDING PHYSICIAN: 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) tached fr 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While at work retained 5-21 1956 . to 4-25 . 19.66. that £0 (we) last 21. I certify that 39 (this hospital) attended the deceased from. DIRECTOR: age 3 should lied with the saw the deceased alive on 66, and that death occurred at 5-45M, from the causes and on the date stated above. 22b. DATE SICNED 22a. SIGNATURE a.m. 6 % ATTENDING PHYS. MED. DIRECTOR 4-25-66 page ere O HOSPITAL PHYSICIANS 22d. ADORESS FUNERAL director, p NAME (Type) Springfield State Hospital NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) BURIAL, CREMATION, 23b, DATE THEREOF REMOVAL (Specify) 25a. KEC'D BY REGISTRAR I 25b. REGISTRAR'S SICNATURE UNERAL DIRECTOR ADDRESS VR A15 (4) 20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05137 CERTIFICATE OF DEATH requir that the death certificate be executed within 24 hours after death. by the funeral Pages 1 and PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) / o. COUNTY **b.** COUNTY Maryland Carroll Howard MARYLAND signed by the attending physician and completely filled in by the furburial-transit permit. Then please remave carban papers. Pages 1 burial, crematian, at remaval, and in any event, within 72 hours after b CITY OR TOWN (If outside corporate fimits, c LENGTH OF STAY IN 16 c EITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) Rural -- Sykesville 2mo. 7days Laurel e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS Springfield State Hospital Route #1 YES NO 3 NAME OF First Middle 4. DATE Last Month Doy Year DECEASED (Type or print) OF 25 66 Ranlett Gladus Ethel 19 DEATH S. SEX B DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 MRS 6. COLOR OR RACE 9 AGE (In years 7 MARRIED **NEVER MARRIED** birthdoy) Hours 8/15/90 white female WIDOWED DIVORCED 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10o USUA, OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? USA Washington D.C. 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Daniel Sullivan unknown WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) 578-09-1290 Springfield Hospital records-Sykesville no 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN ONSEL AND DEATH PART I DEATH WAS CAUSED BY Acute myocardial infarction IMMEDIATE CAUSE (o) physician. DUE TO Conditions, if ony, which gove Occlusion of left coronary artery due to rise to immediate couse (a). DUE TO Page 4 moy be retained by the hospital ar attending I O FUNERAL DIRECTOR: After this certificate has been sdirector, page 3 shauld be detached far use as the k shauld be filed with the State Dept. af Health priar tack stating the underlying couse thrombosis min. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE JERMINA. D SEASE CONDITION G VEN IN PART 1(o).

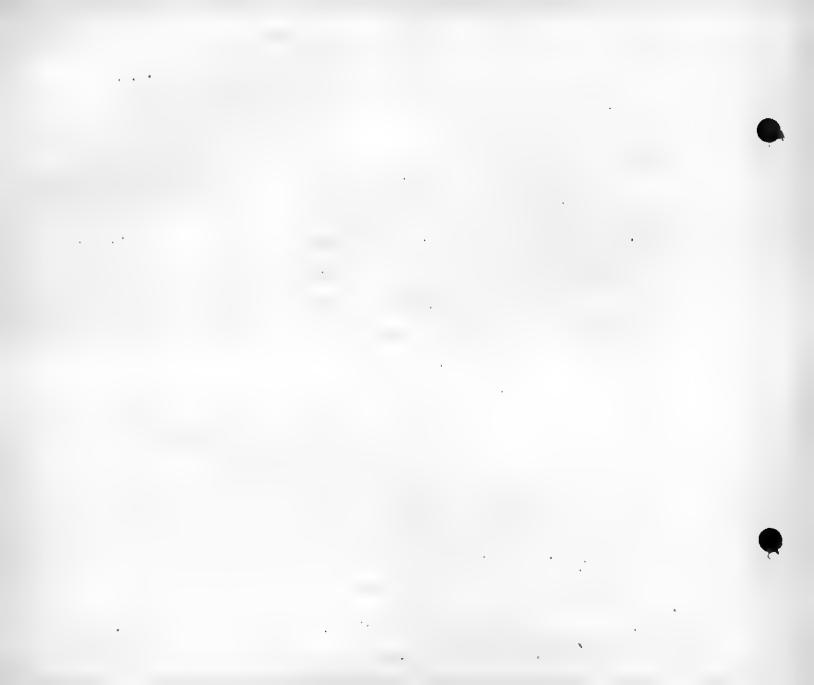
Chronic brain syndrome associated with cerebral arteriosclerosis WAS AUTOPSY PERFORMED? CERTIFICATION with psychotic reaction. YES 📑 NO 200 ACC DENT WAS UNDERLYING [ 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20d INJURY OCCURRED 20s. PLACE OF INJURY (Home, form, (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Hour o.m. foctory, street, office bide, etc.) Not While 19 at work ot work 19 65 that (# (we) last 21. I certify that (this haspital) attended the deceased from 2/18/, 1966, to 4/25/, 1966 that (F(we) last saw the deceased alive an 4/25/ 1966, and that death accurred at 12:35%, from causes and an the date stated above. 1966 saw the deceased alive an 22o. SIGNATURE 22b DATE SIGNED ATTENDING MED STAFF 4/25/66 8 M.D. PHYS Springfield State Hospital 22d ADDRESS 22c PHYSICIAN'S Edmee J. Reeves, M. D. NAME (Type) Sykesville. Maryland 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 230 BURIAL CREMATION REMOVAL (Specify) Burial Arlington, Virginia Arlington National 29 0 ADDRESS hington, 2Sb. REGISTRAR'S SIGNATURE 2SO REC'D BY REGISTRAR The STRECTOR Company VR A15 (4) 1966 20 M 1/66



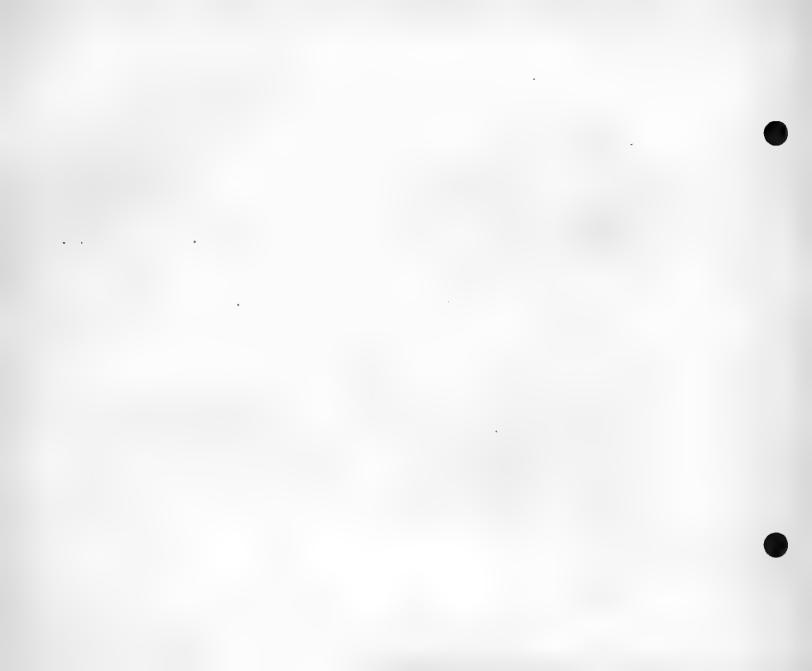
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH by the funeral Pages 1 and 2 ours after death after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, 1f institution; Residence before admission) a. COUNTY b. COUNTY Carroll Carroll Maryland MARYLAND b. CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENCTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) carbon papers. Pagent, within 72 hours 24 hours .5 Westminster Westminster Rt. 3 Rural 1 Month d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) filled i 6. IS RESIDENCE ON A FARM? d. STREET ADDRESS Cranberry Road Rt. #4 Snydersburg Road YES ND:KX executed within completely 3. NAME OF First Middle DATE 4. Month Year Day DECEASED (Type or print) Thomas Rayner April Dewey DEATH 1966 SEX 6. COLOR DR RACE ACE (In years | IFUNDER 1 YEAR | IF UNDER 24 HRS. last Dirthday) | Months | Days | Hours | Min 7. MARRIED DATE OF BIRTH emove NEVER MARRIED Months i Days Hours and any Caucasian Male April 1. 1898 WIDOWED DIVORCED | physician a = 10a. USUAL OCCUPATION (Cive kind of work done | 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY? 11. BIRTHPLACE (County & State, or foreign country) The law requires that the death certificate be during most of working life, even if retired) INDUSTRY Coal Mines Coal Miner Frostburg, Maryland U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending primit. Them Thomas D. Rayner Mary Carr 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SDCIAL SECURITY ND. Address R-1 burial transit permit. burial, cremation, or (Yes, no, or unknwn) (If yes give war or dates of service) Christina Leptic-Brodbecks, Pa. the 18. CAUSE OF DEATH [Enter only one cause per,line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH After this certificate has been signed by d be detached for use as the burial-transi state Dept. of Health prior to burial, crem PART I. DEATH WAS CAUSED BY 'O HOSPITAL OR ATTENDING PHYSICIAN. The law requires that t' Page 4 may be retained by the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which (b) gave rise to Immediate DUE TO cause (a), stating the underlying cause last. (c) PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) CERTIFICATION WAS AUTOPSY 19. PERFORMED? NO 🖂 20a. ACCIDENT WAS UNDERLYING TO DR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) MEDICAL TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, I (State) 20f. (City or town) (County) Not While factory, street, office bldg., etc.) Hour a.m. While at work p.m. at work in FUNERAL DIRECTOR: A director, page 3 should should be filed with the S 21. I certify that (!) (this hospital) attended the deceased from . that (I) (we) last saw the deceased alive on M, from the causes and on the date stated above. and that death occurred at 22a. SUGNATURE 22b. DATE SICNED ATTENDING PHYS. STAFF PHYS. M.D. DIRECTOR __ director, p should be t PHYSICIAN'S 22d. ADDRESS NAME (Type) Donald Knight. BURIAL, CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) 23d. REMOVAL (Specify) Buria Gardens Marvland Evergreen Memorial Finksburg FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 1966 Hampstead, Md. A15 (4)

• . . . requires that the death certificate be executed within 24

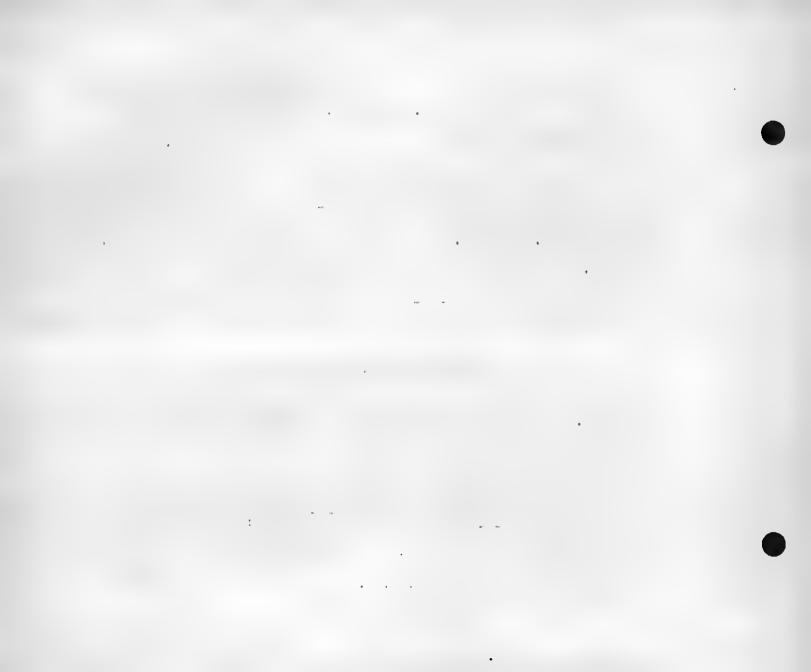
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 5 40 CERTIFICATE OF DEATH funeral after death, and deatl 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY Carroll Maryland MARYLAND Carroll by the afte City OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b within 72 hours hours Westminster 6 vears Westminster = d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) filled d. STREET ADDRESS e. IS RESIDENCE ON A FARM? W. Green Street W. Green Street NO St YES completely ve carbon p NAME OF First Middle Last DATE Month Day Year DECEASED event, RATIPH WHITTHIRY SCOTT 1966 DEATH April (Type or print) 5. SEX AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. | last birthday) | Months | Days | Hours | Min. 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED emove NEVER MARRIED any and white male WIDOWED DIVORCED TO April 21. 1892 = 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT Physician ease and ir during most of working life, even if retired) INDUSTRY COUNTRY? Wilmington. Del. structural designer U.S.A. attending phy Irmit. Then p n. or removal, 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME George Whiteley Bvella Scott 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address transit permit. (Yes, no, or unkown) | (If yes give war or dates of service) 67 W. Green St. 152-07-1065 Mrs. Gladys M. Wimert Westminster, the INTERVAL BETWEEN 18. CAUSE OF DEATH | Enter only one cause per line for (a), (b), and (c). certificate has been signed by the hed for use as the burial-transit t. of Kealth prior to burial, cremai ONSET, AND DEATH ó PART I, DEATH WAS CAUSED BY: the hospital or attending physician. 66 IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) gave rise to immediate DUE TO cause (a), stating the underlying cause last, CERTIFICATION WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO | YES -20a. ACCIDENT WAS UNDERLYING OF CONTRIBUTING OF CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part 1) of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm. 20f. (City or town) (County) (State) det factory, street, office bldg., etc.) Hour a.m. While Not While After retained by at work ATTENDING at work director, page 3 should should be filed with the ould the 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at 6-2AM, from the causes and on the date stated above. saw the deceased alive on 22b. DATE SIGNED 22a. SIGNATURE þ ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. M.D. Page 4 may PHYSICIAN'S 22d. ADDRÉSS NAME (Type 23c. NAME OF CEMETERY OR CREMATOR) LOCATION (City, town or county) (State) BURIAL, CREMATION, 23b. DATE THEREOI REMOVAL (Specify) 2 burial 766 Westminster, Maryland Westminster Cemetery REC'D BY REGISTRAR 24 FUNERAL DIRECTOR ADDRESS 25b. REGISTRAR'S SIGNATURE 1966 VR A15 (4) 15M 4-64



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY s. Pages 1 hours after hours after Carroll by the MARYLAND Marvland Baltimore City b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporete limits, write RURAL end give nearest town) c. LENGTH OF STAY IN 1b Baltimore 12yrs.2mos.26dvs. 5 Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street eddress) filled d. STREET ADDRESS e. IS RESIDENCE ON A FARM? within / Springfield State Hospital 80h Wellington Ave. NO DC YES | completely executed within 4. DATE Middle Last Month Day DECEASED 19 66 ODEN SHERIDAN SHIPLEY APRIL DEATH (Type or print) even 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED and con remove 5. SEX 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. last birthday) | Months | Days Hours 3-11-13 Male White WIDOWED [TT] DIVORCED .= 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR during most of working life, even if retired) | INDUSTRY 12. CITIZEN OF WHAT COUNTRY? physician n please r 11. BIRTHPLACE (County & State, or foreign country) certificate be ease Mechanic at Beth. Steel Co. Marvland U.S.A. removal, 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ed by the attending partransit permit. Then, cremation, or remova Thomas L. Shipley Fannie Shoemaker 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address death (Yes, no, or unkown) | (If yes give war or dates of service) Records, Springfield State Howital 21/1-1/1-9331 INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), ] gned by th ial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Bilateral bronchopneumonia Days been signed the furial-transform to burial, cre Conditions. If any, which Possible infected emboli from right ventricle Days gave rise to immediate the L wall DUE TO cause (a), stating the as th r this certificate has b detached for use as ti te Dept. of Health prior underlying cause last, CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? CBS assoc. with convulsive disorder, without qualifying phrase YES TO NO F 20a. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20f. (City or town) (County) (State) DIRECTOR: After the age 3 should be de filed with the State Hour a.m. While Not While be retained by at work ! at work 21. I certify that (I) (this hospital) attended the deceased from..... 1-8-54 to11-11-66 ___ that (I) (we) last 4-4-66 saw the deceased alive on 19__ ____ and that death occurred at! M. from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED page : ATTENDING PHYS. STAFF PHYS. PHYSICIAN'S NAME (Type) DIRECTOR Page 4 may M.D. O FUNERAL I 22d. ADDRESS Springfield State Hospital Frances Reid Nabors, M. D. Sykesville, Maryland 23d. LOCATION (City, town or county) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (State) BURIAL, CREMATION, REMOVAL (Specify) 9 Carrollton, Md. Church of God Ce. . 4/7/66 REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS 6009 Harford Altenburg -VR A15 (4) Home Inc. 15M 4-64



1 /	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND					
	05142 CERTIFICATE OF DEATH 05141					
should (M)	1. PLACE OF DEATH   2. USUAL RESIDENCE (Where daceased leved, if institutions Residence before edmission)					
S & S	* COUNTY CARROLL MARYLAND MARYLAND MARYLAND MARYLAND MARYLAND MARYLAND MARYLAND MARYLAND MARYLAND					
dea	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest lown)  C. LENGTH OF STAY IN 1b  C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown)					
atte	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give straet address)  d. STREET ADDRESS  a. 15 RESIDENCE					
0.0	37 E, GEORGE ST. 37 E, GEORGE ST VES NO E					
	1. NAME OF DECEASED (Type or print) 4. DATE Month Day Year OF DECEASED (Type or print) 4. DATE Month Day Year OF DECEASED TRY OF DEATH APRIL 19 1966					
	5. SEX 6. COLOR OR RACE 7. MARRIED TO NEVER MARRIED 1 8. DATE OF BIRTH ,9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.					
	MALE WITH TE WIDOWED DIVORCED MAY 17 1898 67 yrs. Months Days Hours Min.					
	100 USUAL OCCUPATION (GIVE kind of work 100 KIND OF BUSINESS OR INDUSTRY 11. 8 RTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?  done during most of working life, even it refired)  ELECTRICIAN BUILDING CARROLL MARYIMD U.S.A.					
)	13. FATHER'S NAME					
	17 UNARD PETER SIES LAURA KATE BURGOON					
,ievoi	(Yes, no, or unkown) (If yes give war or dates of service) 11-10-0331 MRS, MAKY P. SIES					
or rem	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I, DEATH WAS CAUSED BY:  ONSET AND DEATH ONSET AND DEATH					
o, no	IMMEDIATE CAUSE (a) C 14 RC [100 W/ 14 CP L D 106 L YE/3K					
emati	163 X DUE TO Conditions, if any, which (b)					
j j	gave rise to immediate cause (a), staling the underlying DUE TO					
	COURSE lest.  [C]  PART 1. OTHER SIGN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1.0 19. WAS AUTOPSY					
U	PERFORMED?  YES NO					
	PART 1. OTHER SIGN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1,61 19. WAS AUTOPSY PERFORMED?  PERFORMED?  VES NO  OR CONTRIBUTING [] CAUSE OF DEATH  (If EITHER, NOTIFY MEDICAL EXAMINER)					
	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, 20f. (City or lown) (County) (State)  Hour a.m. While Not While lactory, street, office bldg., etc.)					
L.	0.000 60 000 1					
	21. I certify that (I) (this hospital) attended the deceased from 1-1. 1-1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1					
	226 SIGNATURE ATTENDING MED. STAFF LI 226. DATE					
	22c. PHYSICIAN'S Q R D G F ROAD					
1	DATE OF THE LIVER WESTER WESTER ME STER ME STE					
3	236 SORIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town of country) (Slate)  REMOVAL (Specify) 4/2.1/1/4 MEANOW BRANCH (EMETERY WEST WINSTER MD.					
ap	24 FUNERAL DIRECTOR'S SIGNATURE 250 REGISTRAR 256. REGISTRAR'S SIGNATURE					
1 (5)	James - Saffell fr. nastrastER, MAJAPR 20 1966 Judge					



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STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH should. within 24 hours after PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission) a. COUNTY 12 P ayy AYYL MARYLAND Pue deat b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (if outside corporate limits, write RURA), and give neerest town! write RURAL and give neerest town _= Pages affe d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite), give street address hours d. STREET ADDRESS . IS RESIDENCE ON A FARM? papers. n 72 hor completely YES NO [X] 3. NAME OF 4. DATE Midd!e DECEASED and comp carbon pa OF (Type or print) DEATH 1966 5. SEX AGE III years HF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED X NEVER MARRIED B. DATE OF BIRTH death certificate be lest birthday) 100 mg WIDOWED DIVORCED physician, 10a. USUAL OCCUPATION (Give kind of work Stele, or foreign country 12. CITIZEN OF WHAT done during most of working life, even if retired) please C 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME aftending and Alice Spencer John Simmons Then oval, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address [Yes, no, or unknown] | [[fvesalvewerordelesofservice 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE IN cremation. DUE TO affending Conditions, if any, which (b) gave rise to immediate cause DUE TO (a), steting the underlying ceuse last. certificate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY 88 CERTIFICATION PERFORMED? prior use NO TH for 206 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) detached for t. of Health After this OR CONTRIBUTING [ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ģ ATTENDING MEDICAL 2Dc. TIME OF INJURY Month, Day, Yeer 2Dd. INJURY OCCURRED : 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) be retained fectory, street, office bldg., etc. While Not While Hour a.m. DIRECTOR: at work at work p.m. 19 that (I) (we) last ...... 19 21. | certify that (I) (this hospital) attended the deceased from pinous ...1966 State A M, from the causes and on the date stated above ..., and that death occurred at saw the deceased жы 22b. DATE 22e SIGNED ATTENDING STAFF HOSPITAL FUNERAL paged PHYS. DIRECTOR PHYS. 22c. PHYSICIAN'S 22d. ADDRESS Hampstead, Md. director, i NAME (Type) M 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City, fown or county) 23c. NAME OF CEMETERY OR CREMATORY (Slete) Bremoval (Specify) Hampstead Cemetery Hampstead Md. 258. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 1966 VR A15 (4) Funeral Home Hampstead 20M S-63





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral after death, PLACE OF DEATH a. COUNTY USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) filled in by the sars. Pages 1 g a. STATE b. COUNTY CARROLL BALTIMOLE MARYLAND MARYLAND b. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ve carbon papers. Pag event, within 72 hours hours BALT IMORE 2485 - 10 mos-11 ) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 906W. 37 5TREET ND P 57776 YES completely i 3. NAME OF Middle DATE Month DECEASED NMN (Type or print) DEATH APRIL 19 66 5. SEX 6. COLOR OR RACE 8. OATE OF BIRTH AGE (In years | IF UNDER 1 YEAR (IF UNDER 24 HRS remove 7. MARRIEO NEVER MARRIEO last birthday) | Months | Days Hours any FEMNLE WIDDWED DIVORCED Ξ 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? and HOUSEW, FE MARYLAND L1 5.4 certificate N L 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME removal William MCKEE HMELIA ed by the attend transit permit. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? EVER IN U.S. ARMED FUNCES.
[(If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address death RECORDS, SPRINGFIELD HOSPITAL STATE 18. CAUSE OF DEATH [ Enter only one cause per line for (a), (b), and (c),] INTERVAL BETWEEN ONSET AND GEATH After this certificate has been signed by d be detached for use as the burial-transi state Dept. of Health prior to burial, crem PART I. OEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO olized Afteriosclerosis Conditions, if any, which gave rise to immediate DUE TO cause (a), stating as th prior t underlying cause last CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. WAS AUTOPSY CHACKIC BRAW SYNDROME WITH CEREBARL ARPER, CSCLEROSIS WITH PERFORMED? YES NO TV 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 2Da. ACCIDENT WAS UNDERLYING I DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 120e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While be retained by at work at work Page 4 may be recommended to Francis Africactor, page 3 should plnous 4-17-66 19 that (1) (we) last the 21. I certify that (I) (this hospital) attended the deceased from 6-8 and that death occurred at 3:22 M. from the causes and on the date stated above. 66 saw the deceased alive on 4 - 17 _19_ 22a. SIGNATURE DATE SIGNED ATTENOING PHYS. DIRECTOR M.D. PHYSICIAN'S 22d. ADDRESS SPRINGFIELD STATE NAME (Type) SY KES YILLE, MARYLAND C. NAME OF CEMETERY DR CREMATORY BURIAL, CREMATION, LOCATION (City, town or county) (State) REMOVAL (Specify) BALTO, MO. 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE VR A15 (4) 15M 4-64



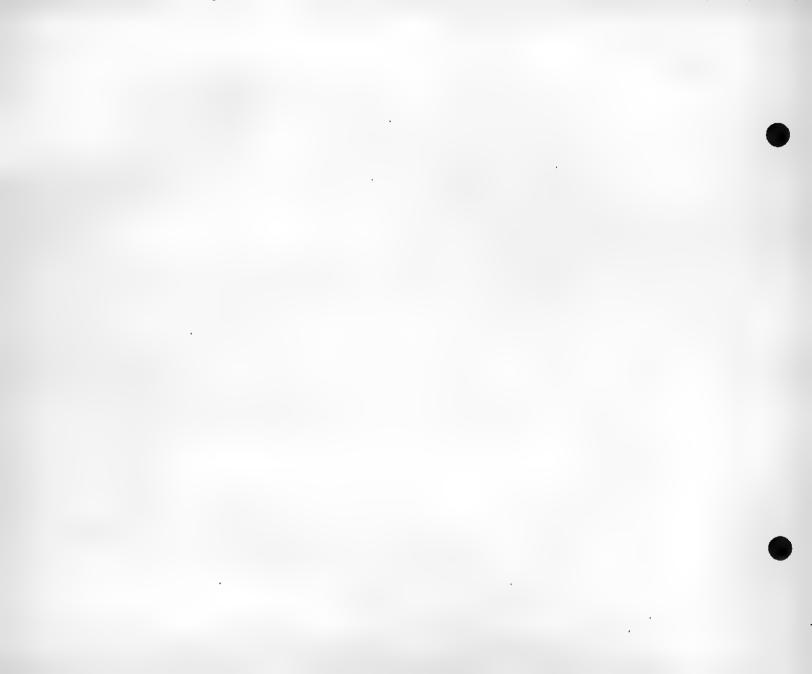
1	DIVISION OF STATISTICAL R		, 301 W. PRESTON		E 1, MARYLAND
<b>=</b> 0	5146	CERTIFICATI	E OF DEATH		05145
	Place of Death a. County Carroll	MARYLAND	a. STATE	nd b. count	rroll
ove carbon papers. Pigges, and 2 / event, within 72 hours and death.	b. CITY OR TOWN (if outside corporate limit write RURAL and give nearest town)  Sykesville	2yr.6mos.23dys	. Woodbi		e RURAL and give nearest town)
72 l	d. NAME OF HOSPITAL OR INSTITUTION (If no		d. STREET ADDRESS	-	6. IS RESIDENCE ON A FARM?
# / º _	Springfield State Ho:	<del></del>			YES NO X
3	(Type or print) JOHN	JACOB	SNYDER		Day Year 120 19 66
	Male White WID	OWED Septivorced	4-12-74	9. AGE (In years III last birthday) A	
10 di	Da. USUAL OCCUPATION (Give kind of work done uring most of working life, even if retired)  Carpenter	10b. KIND DF BUSINESS DR INDUSTRY	11. BIRTHPLACE (Cou	nty & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	3. FATHER'S NAME Surgle	_	14. MOTHER'S MAIDEL	y Jane Lear	selving
C	5. WAS DECEASED EVER IN U.S. ARMEDFORCES? Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 17. 214-16-0951-A	Records. Sp	Address ringfield Stat	•
lied with the State Dept. of Health prior to burial, cremation, or removal, and in any Medical Certification	PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  4 2 2   DUE TD  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (c)	Arteriosclerotic	Cardie-vasc	mlar Disease	
CERTIFICATION				•	YES NO XXX
MEDICAL		20d. INJURY DCCURRED   20e. PLA While Not While facto	CE DF INJURY (Home, farr ry, street, office bldg., etc	m, 20f. (City or town)	(County) (State)
	21. 1 certify that (I) (this hospital) a	nn //	ATTENDING MI	to 1-20-66	2, 19, that (I) (we) last and on the date stated above.  22b. DATE SIGNED  1-20-66
1	22c. PHYSICIAN'S NAME (Type) Octavio A.	Ruiz, M.D.	22d. ADDRESS S	pringfield Sta ykesville, Mar	te Hospital yland 21784
_	3a. BURIAL CREMATION, 23b. DATE THERED REMOVAL (Specify) 4/23/4. FUNERAL DIRECTOR	ADDRESS NAME OF CEMETERY	Pendlera		M SIGNATURE
)	4,5, miters bi	West musister,	MARR 2	2 1966 Jelia	nes judge



-11	1 (		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND	
	4 F02		OSTAT CERTIFICATE OF DEATH 05146	,
	death, and 2 death		1. PLACE OF DEATH 9. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admis	sion)
	ter he f s 1 fter		MARYLAND a STATE b. COUNTY	
	s af		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	)wn)
	hour S. 5 bou		The Mark of Dave Co.	2
	n 24 hours after death, y filled in by the funeral papers, Pages 1 and 2 hin 72 hours after death,	10	Tongrew he as theme 128 main. John Lani (no hunter) VES 10 NO	1
	PHYSICIAN: The law requires that the death certificate be executed within the hospital or attending physician, this certificate has been signed by the attending physician and completely detached for use as the burial-transit permit. Then please removed show the Dept. of Health prior to burial, cremation, or removal, and in any execut.	1	3. NAME OF DECEASED First Middle Last 4. DATE Month Day Year	/
	Pa (Sp.		(Type or print)	HRS.
	executed and com remover		WINDWED TO DIVERGE TO DIVERGE TO TAKE THE LAST DISTRIBUTED IN MONTHS Days Hours N	viin.
	an a		1Da, USUAL OCCUPATION (Give kind of work done   1Db. KIND OF BUSINESS OR   11. BIRTHPLACE (County & State, or foreign country)   12. CITIZEN OF WHAT	
	physician physician n please val, and in		+ armer / Dallo to Parkalle my U.SA	
	ficat r phy en p oval,		13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	
	certifica iding ph Then removal		15 WAS DECEASED EVED IN I C. ADMIT SOCIETA LAS SOCIETA DE SOCIETA	
	e death certifica the attending ph it permit. Then tation, or removal		15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service)	ZLZF
	de d		18. CAUSE OF DEATH [Enter only one cause pgr-line for (a), (b), and (c).]	14
	res that the deal physician. signed by the al purial-transit pem ourial, cremation,		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (ere had thrombos  ONSET AND DEAT  WELL	
	that sicia ned al-tra al, ci		332X DUE TO COLORS (3)	
	ires tha physici n signe burial-ti burial-ti		Conditions, If any, which \ (1) (1) (1) (1) (1)	)_
	ding p ding p been the bi		gave rise to immediate ( cause (a), stating the ( DUE TO	7
	law rei ttendir has be as th as th		underlying cause last. (c)	
	N: The law requires that the fact of or attending physician, afficate has been signed by for use as the burial-tran. Health prior to burial, cre		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  PERFORMED  YES NO  20a. ACCIDENT WAS UNDERLYING 1 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  OR CONTRIBUTING 1 CAUSE OF DEATH  (If EITHER, NOTIFY MEDICAL EXAMINER)	
	To Silver The Table The Ta	0	YES NO  20a. ACCIDENT WAS UNDERLYING 2   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
	PHYSICIAN: The la the hospital or att this certificate h letached for use Dept. of Health		20a. ACCIDENT WAS UNDERLYING   2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.)  GCONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
	PHYSI the h this detacl		20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, 4 County) (State factory, street, office bldg., etc.)    Post	e)
			Hour a.m. While Not While at work at work	
			21. I certify that (I) (this hospital) attended the deceased from 4- 19 to 4- 1, 19 to 4-	last
	OR ATTEN / be retain OIRECTOR: Ige 3 shoul		saw the deceased alive on 4 6 1966, and that death occurred at 4 3 M, from the causes and on the date stated abi	Dve.
	ed Se Be		ATTENDING AMED STAFF - 1/2 6	
		7	22c. PHYSICIAN'S M. C. Porterfield 22d. ADDRESS NAME (Type) M. C. Porterfield 22d. ADDRESS NAME (Type) M. C. Porterfield	_
	e 4 INER		Trained (1996) 115 Oct 1 Col I Louis	
	TO HOSPITAL Page 4 may TO FUNERAL director, pa		23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)	
	F F		Burial 4-11-1966 St. John's Cemetery Baltimore, Co. Mid.  24. FUNERAL DIRECTOR ADDRESS CO. 1 25a. REC'D BY REGISTRAR'S SIGNATURE	
	VR A15 (4)		23d. REC D BY REGISTRAN'S SIGNATURE	
	20M 1/65		wassamming Home 1 10 1 Balons Krall DAPPR 1 2 1966 June June	-==



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 05148CERTIFICATE OF DEATH funeral 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. COUNTY acro. MARYLAND CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENCTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) by 1 Page on papers. Pag within 72 hours mak Mal 므 filled d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital/give sweet address d. STREET ADDRESS B. IS RESIDENCE NO X mari YES executed within etely NAME OF First Middle Last 4. DATE Month Day DECEASED OF 19 66 (Type or print) In b DEATH 5. SEX 6. COLOR OR RACE AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS | last birthday) | Months | Days | Hours | Min. NEVER MARRIED 8. DATE OF BIRTH 7. MARRIED [ and emo WIDOWED DIVORCED [ yrs. physician an please reval, and in = 10a. USUAL OCCUPATION (Cive kind of work done | 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? 11. BIRTHPLACE (County & State, or foreign country) death certificate be during most of working life, even if retired) arro FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INEDRMANT the attend it permit. Address (Yes, no, or unkown) (If yes give war or dates of service) cremation, CAUSE OF DEATH | Enter only one cause per line for (a). NTERVAL BETWEEN -transit The law requires that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) the hospital or attending physician. signed been signer the burial-t DUE TO Conditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating the underlying cause last. (c) 88 CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) WAS AUTOPSY for use Health nse PERFORMED? certificate YES [ NO P PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INDIRY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) detached for the Dept. of I MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) (County) factory, street, office bldg., etc.) Hour a.m. While. Not While After OR ATTENDING be retained by at work p.m. at work 1966 70 21. I certify that (I) (this hospital) attended the deceased from __. 19 66 that #7 (we) last DIRECTOR: shoul and that death occurred at// M, from the causes and on the date stated above. saw the deceased alive on. 3 sho 22a. SICNATURE DATE SICNED director, page 3 should be filed w MED. DIRECTOR Fage 4 may 1 FUNERAL ADDRESS 22c. PHYSICIAN'S NAME (Type) NAME OF CEMETERY OR CREMATOR 23a. BURIAL, CREMATION, 23b. DATE THEREOF LOCATION (City, town or county) (State) REMOVAL (Specify) 9 NIO N **FUNERAL DIRECTOR** ADDRESS' 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR AL5 (4) 20M 1/65



1 程	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
4 504	05143 Item CERTIFICATE OF DEATH 115148
hours after death. d in by the funeral rrs. Pages 1 and 2 thours after death.	1. PLACE OF BEATH a. CDUNTY b. COUNTY b. COUNTY
rs afte by the Pages urs afte	b. CITY OR TOWN (If botside corporate limits, c. LENGTH DE STAY IN 1b c. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town; write RURAL and give nearest town;
hours and in by Frist. Page 2 hours	d NAME OF HUSPITAL OR INSTITUTION (If not in hospitat, give street address) d. STREET ADDRESS  e. IS RESIDENCE ON A FARMI
r fille pape hin 7.	Haler Just Herre 8406 Cillenvictor Je on A FARME
within hipletely carbon carbon int, within	3. NAME DF DECEASED (Type or print)  Service of the print
and completed with any complete remove carl in any event,	5. SEX S. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years   FUNDER 1 YEAR   IF UNDER 24 HR
E	10a. USUAL OCCUPATION (Give kind of work done of industry)  10b. KIND DF BUSINESS OR 11/BIRTHPLACE (County & State, or foreign country)  12. CITIZEN OF WHAT COUNTRY?
+ ≥0	13. FATHER'S NAME
certificate be nding physicia . Then please removal, and I	Lichard Baker Trancy Price
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address of Service) NEW Rand of Solve War or dates of service) NEW Rand of Solve Stansberry Management of Stansber
a str	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART 1. DEATH WAS CAUSED BY:
es that the ohysician. signed by t urial-transit ourial, crema	IMMEDIATE CAUSE (a)  DUE TO  DUE TO
uires the physical signal burial.	Conditions, if any, which gave rise to immediate (b)
law requires that the trending physician. has been signed by the safe burial transit prior to burial, cremal	cause (a), stating the DUE TD underlying cause last.
4: The law isl or attentificate has for use as Health price	PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO
PHYSICIAN: The law requires that the hospital or attending physician, this certificate has been signed betached for use as the burial-trane Dept. of Health prior to burial, cre	PERFORMED? YES NO 202. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.) BY CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
PHYSICIAN: the hospita this certifi detached fo e Dept. of H	20c. TIME DF INJURY Month, Day, Year   20d. INJURY OCCURRED   20e. PLACE OF INJURY (Home, farm,   20f. (City or town) (County) (State)
tage of the state	
ATTENDIN retained to IECTOR: Aff 3 should b with the S	21. I certify that (I) (this hospital) attended the deceased from 19/10, that (I) (we) last saw the deceased alive on 19/10, and that death occurred at 19/10, from the causes and on the date stated above
	228. SIGNATURE  M.D. ATTENDING MED. STAFF  PHYS.   22b. DATE SYCNED   4/25/6/6-
O HOSPITAL OR ATTENDIR Page 4 may be retained o FUNERAL DIRECTOR: Af director, page 3 should is should be filed with the S	22c. PHYSICIAN'S NAME (Type) 1 N/A 97/ N 22d. (ADDRESS )
Page O FUN direct Shoul	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
nf.	24. FUNERAL DIRECTOR 258. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE
VR A15 (4) 2DM 1/65	Fring Byon. State State doctores and PR 28 1968 followers Judge



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 15150 be executed within 24 haurs after death. death 2 USUAL RESIDENCE (Where deceased fived, if institution. Residence before admission) and campletely filled in by the funeral remove carban papers. Pages 1 and PLACE OF DEATH o. STATE Maryland d. COUNTY Carroll b. COUNTY Baltimore City MARYLAND ease remove carban papers. Pages 1 and in any event, within 72 haurs after b (ITY OR TOWN (if outside carporate limits, write RURAL and give nearest town)

Sykesville c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) 23vrs.2mos.6dvs. Baltimore B IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) d STREET ADDRESS Springfield State Hospital Exact address unknown YES NO 🛣 3 NAME OF First Middle 4 DATE Last Month Day Year DECEASED ETHEL SIMES STEINER APRIL 25 19 66 (Type or print) DEATH IF UNDER 1 YEAR I IF UNDER 24 HRS. S SEX 6. COLOR OR RACE B. DATE OF BIRTH AGE (In years 7 MARRIED NEVER MARRIED Rigst birthdoy) Months Dovs Hours Female White 11-211-1883 Sep • DIVORCED WIDOWED 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State arforeign country) 12 CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY U.S.A. New York requires that the death certificate 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME burial, cremation, or remayal, the attending phy sit permit. Then John Mulligan Isabel Simes 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) 16-46-3747 Records. Springfield State Hospital INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one cause per line far (o), (b), and (c).) signed by the burial-transit p DASET AND DEATH PART I. DEATH WAS CAUSED BY Severe bronchopneumonia IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital ar attending physician. DUE TO Arteriosclerotic heart disease Years Conditions, if only, which gove rise ta immediate couse (a), **DUF TO** as the l stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been Generalized arteriosclerosis Years PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) Schizophrenic reaction, parahoid type WAS AUTOPSY PERFORMED? far use Health p YES 🗔 NO X 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18) 20o. ACCIDENT WAS LINDER, YING [7] detached for the Dept. af H OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER with the State Dept. 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, (City or town) (County) (State) factory, street, affice bldg., etc.) Nat While ot work 21. I certify that (I) (this haspital) attended the deceased fram_ 2-19-43 _, 19...., that (I) (we) last and that death occurred a 0:05 shauld 4-25-66 M. from causes and on the date stoted above. sow the deceased alive an 22b. DATE SIGNED 22a SIGNATURE ATTENDING STAFF PHYS. 4-25-66 DIRECTOR M.D. 2122 621 director, page should be filed 22d. ADDRESS Springfield State Hospital BHYSICIAN S Agustin del Campo, NAME (Type) Sykesville. Maryland 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 230 BURIAL CREMATION 23b DATE THEREOF (State) Burial (Specify) 1966 Greenmount Bal timore Md 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2Sq. REC'D BY REGISTRAR York Road .Jenkins Sons Co



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the deoth certificate be executed within 24 hours after death. r filled in by the funerol n gopers. Pages 1 and 2 ithin 72 hours after death death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH o. COUNTY a STATE b. COUNTY Carroll Maryland MARYLAND b CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If gutside camparate limits, write RURAL and give nearest tawn) Sykesville Raltimore 21216 davs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Springfield State Hospital 3h05 Duvall Avenue NO DE YES: 3 NAME OF Middle 4 DATE pou First Lost Month Day Year DECEASED Katharine STEPHENS 1966 Mary April 24. (Type or print) DEATH I YEAR IF UNDER 24 HRS S SEX AGE (In years IF UNDER 6 COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH ast birthday) Months Hours Days 9-28-187% white [X female WIDOWED DIVORCED crematian, or removal, and in any 10a JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHP ACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even, if retired) COUNTRY? INDUSTRY Maryland none -AT Home 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John T. McMahon - dec. Katherine Wallace - dec. IS WAS DECEASED EVER IN U.S. ARMED FORCES? Tephens - 1315-TALbot 16. SOCIAL SECURITY NO. 17. INFORMANT signed by the offendir buriol-tronsit permit. (Yes, no, or unknown) [(If yes give wor or dates of service) 213-54-1807 Springfield State Hospital Records none PART I DEATH WAS CAUSED BY INTERVAL BETWEEN heart failure. ONSET AND DEATH MMEDIATE (AUSE (a) Arteriosclerotic heart disease with congestive DUE TO burnol, Conditions, if any, which gove (b) Generalized arteriosclerosis. vears rise to immediate cause (a). DHE TO stating the underlying couse as the Page 4 may be retained by the hospital or ottending O FUNERAL DIRECTOR: After this certificate has been last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use NO Ex 205 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 1B.) 20a ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH 3 should be detached with the State Dept. of (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame farm. (City or town) (County) (State) 20c TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Not While at wark 3 should be 21. I certify that (1) (this hospital) attended the deceased fram_saw the deceased glive an 4-24-66 19 and the to 11-211-66, 19, that (1) (we) lost 4-14-50 19 and that death accurred at 3 p.M. from causes and an the date stated abave. saw the deceased alive an -22a SIGNATURE 22b. DATE SIGNED STAFF 4-24-66 DIRECTOR director, poge should be filed 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Antonius Glahr ykesville. Maryland 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) 230 BURIAL, CREMATION. 23b DATE THEREOF (County) BEMOVAL (Specify) 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2So. REC'D BY/REGISTRAR VR A15 (4)

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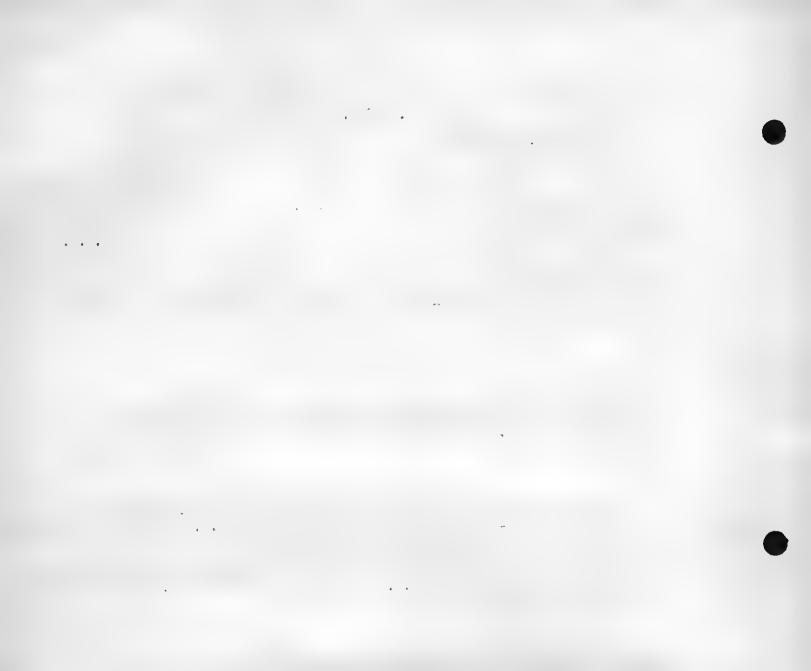
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH after death and deal PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. CDUNTY **b. CDUNTY** Carrol1 Carrol1 MARYLAND Maryland Pages b. CITY DR TOWN (if outside corporate limits, c. LENGTH DF STAY IN 1b c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) hours Rural, Westminster 6 Years Rural, Westminster bon papers. within 72 ho filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS e. IS RESIDENCE DN A FARM? Westminster, Md. R. D. 4 Westminster, Md. R. D. 4 ND etely NAME DE Middle DATE Year Last DECEASED (Type or print) April DEATH 19 66 certificate be executed SEX 6. COLDR DR RACE AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIED NEVER MARRIED last birthday) | Months | Days Hours WIDDWED I DIVORCED [ 10/7/1896 a 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or fereign country) sician lease during most of working life, even if retired) INDUSTRY CDUNTRY? Housewife-Housework The Family Home Carroll County, Md. U.S.A. physic n plea 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remova attending permit. Then John Stonesifer Ellen Stonesifer 15. WAS DECEASED EVER IN U.S. ARMED FDRCES?
(Yes, no, or unknown) | (If yes give war or dates of service) d by the attend transit permit. cremation, or n 16. SDCIAL SECURITY ND. 17. INFORMANT Address death Mrs. Mazie Zepp Westminster, Md. R.D.1 218-52-3477 CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN requires that the signed by a burial-transit burial, crema DNSET AND DEATH PART I. DEATH WAS CAUSED BY: (1) attending physician. Cenditions, If any, which gave rise to immediate 유민 DUE TO cause (a), stating the prior underlying cause last. PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTDPSY PERFORMED? certificate YES ND [7 2Da. ACCIDENT WAS UNDERLYING DON'T CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) - 5 detache 20c. TIME DF INJURY Month, Day, Year 20d. INJURY DCCURRED | 20e. PLACE DF INJURY (Home, farm, (State) 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. While Not While at work at work p.m. 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: and that death occurred at 400M, from the causes and on the date stated above. saw the deceased alive on DATE SIGNED 22a. SIGNATURI 22b. page ATTENDING PHYS. DIRECTOR PHYS. FUNERAL PHYSICIAN'S 22d. ADDRESS lirector, p NAME (Type) director should BURIAL, CREMATION, 23b. DATE THEREDF 23c. NAME OF CEMETERY OR CREMATORY 23d. LDCATION (City, town or county) (State) REMOVAL (Specify) Bachmans Valley Cemetery Bachmans Valley, Carroll Co. Furial 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE TUNERAL DIRECTORS VR A15 (4) 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH and 2 death after death. 1. PLACE DF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY a. STATE b. COUNTY and completely filled in by the 1 remove carbon papers. Pages 1 any event, within 72 hours after Carroll Maryland MARYLAND Maryland Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b hours Sykesville mos. 2 d. STREET ADDRESS dvs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? Springfield State Hospital NO 3 33 West Wilson Boulevard YES executed within 3. NAME DE DATE First Month Year Middle Last 4. DECEASED SUSAN TICE STOUFFER 19 66 (Type or print) DEATH April 6. COLOR OR RACE | 7. MARRIED 5. SEX DATE OF BIRTH IF UNDER 24 HRS AGE (In years | IFUNDER 1 YEAR NEVER MARRIED last birthday) | Months | Days Hours Female White WIDOWED T 10-23-1886 79 DIVORCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) physician and physician please revenue. 10b, KIND DF BUSINESS OR Ξ 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT that the death certificate be COUNTRY? INDUSTRY Maryland U.S.A. Seamstress n signed by the attending physburial-transit permit. Then pl burial, cremation, or removal, 13. FATHER'S NAME 14. MDTHER'S MAIDEN NAME George Sterling Anna Newcomer 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY ND. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) 220-05-6176A Records. Springfield State Hospital 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: the hospital or attending physician. IMMEDIATE CAUSE (a) ARTERIOS CLEROTIC HEART DISEASE "NO CEREBRAL ARTERIOS CLER OSIS VENKS 4200 DUE TO requires Conditions, if any, which (b) GENERALIZED ARTERIOSCLEROSIS been gave rise to immediate as the prior to **DUE TO** (a), stating the underlying cause last. certificate has CERTIFICATION PARTIL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATHBUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(2) Chronic brain syndrome associated with senile brain disease, with WAS AUTOPSY for use PERFORMED? psychotic reaction. YES [ NO X 20a. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) of o FUNERAL DIRECTOR: After this certirector, page 3 should be detached nould be filed with the State Dept. of WEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20f. (City or town) (County) (State) Hour a.m. While Not While be retained by at work at work OR ATTENDIN 21. I certify that (I) (this hospital) attended the deceased from 4-5-66 19 that (I) (we) last 19 and that death occurred a: 15 M. Nom the causes and on the date stated above. saw the deceased alive on 22b. DATE SIGNED 22a. SIGNATURE ATTENDING PHYS. Page 4 may PHYS. M.D. DIRECTOR PHYSICIAN'S NAME (Type) pringfield State Hospital 22c. 22d. ADDRESS director, p should be 1 Springileto Maryland Sykesville, Maryland Campo. Agustin del 23a. BURIAL, CREMATION, 23b. DATE THEREO 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) REMOVAL (Specify) 9 FUNERAL DIRECTOR REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS Marles 1966 VR A15 (4) 15M 4-64



1/	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, M	ARVIAND
= ~(M)	05154 CERTIFICATE OF DEATH	05153
24 hours after death.  Silled in by the funeral apers. Pages 1 and 2 and 2 hours after death.	1. PLACE OF OEATH a. GOUNTY 2. USUAL RESIDENCE (Where deceased lived, it institution: Re	sidence before admission?
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aft y th ages s aft	D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	and give nearest town)
ours fin b	Sykesville 37yrs.6mos.26dys. Baltimore	M 13
t ho led	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
T 0.2 / 1	Springfield State Hospital (unknown)	YES NO X
executed within and completely remove carbon is any event, within	3. NAME OF FIRST Middle Last 4. DATE Month OF	Day Year
d w car ent,	(Type or print) JOHN D. STREAKER DEATH APRIL	22 19 66
executed and con remove	5. SEX 6. COLOR OR RACE 7. MARRIEO NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years   IFUNDER! last birthday) Months	Davs Hours Min.
execu and remo	Male   White   WIOWED   DIVORCED   7-1-09   56 yrs.	
be cian ase ad in		TIZEN OF WHAT UNTRY?
an Gersie		.S.A.
oe bi	and the state of t	
1号 1号	John W. Streaker Mary E. Donaldson  15. WAS DECEASED EYER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17. INFORMANT Address	
Leath ne atter permit. ion, or	(Yes, no, or unknown) (If yes give war or dates of service)	
he z	No None Records, Springfield State Hos	spital
tille by t nsrt ema	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia in status epilepticus	INTERVAL BETWEEN DNSET AND DEATH
hat curred tra	1 1 1 3 A 2 7	Minutes to
hysign sign rial	Conditions of any subleb 1	hours. Ninutes
	gave rise to Immediate (	113114,005
adir.	cause (a), stating the OUE TO underlying cause last. (c)	
The law requires that the or attending physic	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY
or or cate r us	Chronic brain syndrome associated with convulsive disorder, without qualifying phrase.  20a. ACCIDENT WAS UNDERLYING 1 CODE. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)  CR CONTRIBUTION COLUMN COL	PERFORMEO?
AN.	20a. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
SICU hosp chec		
this beta	20c. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED   20e. PLACE OF INJURY (Home, farm, Hour a.m.   While   Not While   at work   at work   at work   at work	ity) (State)
trate trate	Hour a.m.   While   factory, street, office bidg., etc.)   p.m. 19   at work   at work	
O HOSPITAL OR ETTENDING PHYSICIAN: The law requires that the Death certificate be especially be set any be retained by the hospital or attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician is director, page 3 should be detached for use as the burial-transit permit. Then please in should be filled with the State Demt. of Health prior to Demial, cremation, or removal, and in	21. I certify that (th (this hospital) attended the deceased from 9-26 , 1928, to 4-22 , 196	6, that (!)-(we) last
TTE etain TOR Should the to	saw the deceased alive on 4-22 19.66, and that death occurred a A.M, from the causes and on the	
RECOMMINATION OF THE PARTY OF T		TE SIGNED 2-66
All of an transfer file	M.D. PHYS. OIRECTOR PHYS. X 4-2  22c. PHYSIGIAN'S	2=00
PITA A m Or,	NAME (Type) Ilse Kamm, M.D. Sykesville, Md.	
HOSPITAL age 4 may FUNERAL rector, pa		nty) (State)
5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	REMOVAL (Soecify)	
0	24. FUNERAL OIRECTOR ADDRESS   25a, a DEGLO BY REGISTRAR   25b, REGISTRAR	SIGNATURE
VR AI5 (4)	Burgee Funeral Home 3631 Falls Road OATE 25 1966 Clearly	o Judge
20M 1/65	Horace F. Durgel	U



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY **b.** COUNTY Carroll Baltimore MARYLAND Maryland and completely filled in by the remove carbon papers. Pages and event, within 72 hours aft b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Sykesville prs.lmos.5dys. Baltimore d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Springfield State Hospital NO -1733 Terrell be executed within 3. NAME DE CATE Month Middle Last 4. DECEASEO WILLIAM MMN SYKES (Type or print) **ÖEATH** Apri] 19 6. COLOR OR RACE | 7. MARRIEO | NEVER MARRIEO AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. last birthday) | Months | Days | Hours | Min. 5. SEX DATE OF BIRTH Male Whi te WIOOWED [ DIVORCED 8-21-02 63 10a. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT COUNTRY? <u>.</u> 10b. KING OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) Sician Tease r and in during most of working life, even if retired) INDUSTRY Laborer Transpotation U.S.A ing physical Then plex Maryland Baltimore certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remonal. attending John Schellenberger Mary E. Robinson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? ed by the attend transit permit. cremation, or ru 16. SOCIAL SECURITYNO. Hellman 3006 Weaver Ave death (Yes, no, or unkown) (If yes give war or dates of service) No Records, Springfield State Hospital INTERVAL BETWEEN CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] requires that the been signed by the burial-transit or to burial, crema ONSET AND DEATH PART I. CEATH WAS CAUSED BY: attending physician. Coronary artery thrombosis minutes IMMEDIATE CAUSE (a) **DUE TO** Conditions, If any, which rise to Immediate **QUE TO** has by as th prior t Far advanced pulmonary tuberculosis, active years underlying cause last. The law PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Chronic brain syndrome associated with brain trauma, gross force, with WAS AUTOPSY CERTIFICATION for use Health PERFORMEO? certificate hospital or NO TO YES psychotic reaction. 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF GEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury in Part 1 or Part 11 of Item 18.) etached 1 Dept. of MEDICAL (State) 20d. INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) 20c. TIME OF INJURY Month, Oay, Year det After the delayed of the After I factory, street, office bldg., etc.) Hour a.m. Not While p.m. at work at work retained DIRECTOR: A age 3 should led with the ___, that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased from L-6-66 M. from the causes and on the date stated above. saw the deceased alive on. and that death occurred at 22b. DATE SIGNED 22a. SIGNATURE FUNERAL Din. **8** 9 ATTENDING PHYS. MEO. DIRECTOR 4-6-66 M.O. ADDRESS Springfield State Hospital 22C. PHYSICIAN'S 22d. director, p NAME (Type)Julian Radzykewycz, Sykesville, Maryland 2178h LOCATION (City, town or county) NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION, 23b. DATE THEREOF 23a. REMOVAL (Specify) 2 Baltimore Cemetery Baltimore 25b. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR ADDRESS 25a. 24. FUNERAL DIRECTOR INC BALTIMORE VR A15 (4) 20M 1/65



TON STREET, BALTIMORE 1, MARYLAND PLACE OF DEATH 7. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission e. COUNTY h. COUNTY 유건 and 2 death. MARYLAND b. CITY OR TOWN (if outside corporeta limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown) write RURAL and give negrest town) after anchester Pages executed within filled i NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) d. STREET ADDRESS . IS RESIDENCE papers. Pag n 72 hours a ON A FARM? YES NO DA completely NAME/OF DATE Middle Lost DECEASED OF (Type or print) DEATH 1966 withi carbon 5. SEX 9. AGE IIn Yeers IF UNDER 24 HRS NEVER MARRIED and last birthdey) Months DIVORCED 10a. USUAL OCCUPATION [Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY CITIZEN OF or foreign country WHAT COUNTR done during most of working life, even if retired? سستس please rei been signed by the attending phy 13. FATHER'S NAME 2 Bud requires that the 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMAN (Yes, no, or unkown) | (If yet give war or deles of service Dermit. aftending physician. 18. CAUSE OF DEATH [Enter only one cause per line for INTERVAL BETWEEN ONSET AND DEATH ō PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e. **burial-transit** DUE TO Conditions, if any, which gave rise to immediate cause **DUE TO** (a), steting the underlying certificate has cause last. the the hospital or PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) | 19. WAS AUTOPSY CERTIFICATION 80 PERFORMED? NO use prior 208 ACCIDENT WAS UNDERLYING | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Pert I or Pert II of item 18.) OR CONTRIBUTING [] CAUSE OF DEATH UF EITHER, NOTIFY MEDICAL EXAMINER detached MEDICAL 20c. TIME OF INJURY Month, Dev. Yeer 20d. INJURY OCCURRED I 20e, PLACE OF INJURY (Home, ferm, ) (County) (State) fectory, street, office bldg., etc.] While Not While Hour a.m. ō at work at work p.m. DIRECTOR: 21. I certify that (I) (this hospital) attended the deceased from .... ... 1966..., and that death occurred at 9. A M, from the causes and on the date stated saw the deceased alive on above 22a SIGNATURE 22Ь. DATE ATTENDING MED. SIGNED PHYS. DIRECTOR PHYS. M.D death. Page 4 with ± 22c. PHYSICIAN'S 22d, ADDRESS NAME (Type) ector, I 236. BURIAL, CREMATION, | 236. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Stete) REMOVAL (Specify) Ç ÷ å 1966 Manchchester Cemetery Manchester Md. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE Tipton- Eline Funeral Home Hampstead, Md. VR A1S (4) 20M S-63



1 1	DIVISION OF STATISTICAL RESEARCE	AND STATE DEPARTMENT OF HEALTH CH AND RECORDS, 301 W. PRESTON STREET,	BALTIMORE 1, MARYLAND
a' evel	05157	CERTIFICATE OF DEATH	05156
24 hours after death filled in by the funeral apers. Pages 1 and 2 apers. Pages 1 and 2 apers.	1. PLACE OF DEATH a. COUNTY  ARROLL	MARYLAND a. STATE MARYLAND	d lived, If institution: Residence before admission b. COUNTY (arma)
hours at in by the sage is thours a	Write KUKAL and give nearest town)	Life HAMDSTEA	to limits, write RURAL and give nearest town
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospit	12 Gill A	e. IS RESIDENC ON A FARM? YES □ NO
≥ 彩電視 ≒	3. NAME OF DECEASED First DECEASED Type or print)  5. SEX   6. COLOR OR RACE   7. MARRIED	Middle  SELLE TPTON  NEVER MARRIED   8. DATE OF BIRTH  19. AC	Month Day Year  FP P1 25 19 65  Et (In years   FUNDER 1 YEAR   FUNDER 24 HR  St Dirthday)   Months   Days   Hours   Min
execu n and remo in any	To USUAL OCCUPATION (Give kind of work done during grost of working life, even if retired)  NOUS AND INDUSTRIES OF WILLIAM STATE OF THE PROPERTY OF THE PROPER	DIVORCED JULY 4, 60	Tyrs.
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death certi he attending permit. Th ion, or rem	15. WAS DECEASED EVER IN VS. ARMED FORCES? 16. SOCI (Yes, no, or unkown) (If yes give war or dates of service)	ALSECURITY NO. 17. INFORMANY	Address
nt the death an. d by the after ransit permit. cremation, or	PART I. DEATH WAS CAUSED BY:	or (a), (b), and (c).	INTERVAL BETWEEN ONSET AND DEATH
requires the ding physic been signed the buria-to buria-to buria-to burial.	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	Rinte Culer Vascela &	Jessie Jessie
0 0	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS	TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITI	YES NO
YSICIAN hospit is cert tached bept. of		Y OCCURRED   20e. PLACE OF INJURY (Home, farm,   20f. (City	
	Hour a.m. While p.m. 19 at work	Not While factory, street, office bldg., etc.)	or town) (County) (State)
OR ATTENT be retaine IRECTOR: c 3 should d with the	21. I certify that (I) (this hospital) attended to saw the deceased alive on 4777 24	ATTENDING MED.	the causes and on the date stated above  22b. DATE SIGNED  STAFF PHYS. April 25, 1966
HDSPITAL age 4 mar FUNERAL rector, par iould be fi	22c PHYSIC PAYS NAME HYDE  NAME HYDE  231. BUDYAL, CREMATION, 23b. DATE THEREOF 23	MD ZAMPSTEMO	Mangland  ION (City, town or county) (State)
5 5 5 2 W	Burial April 28, 1966	Hamps tead Cemetery Hamps 1 ADDRESS 125a REC'D BY REGISTRA	tead. Md.
VR AIS (4) 20M 1/65	Tipton - Eline Funeral Home	Hampstead, Md. DAMAY 2 196	68 Jelianles Judge

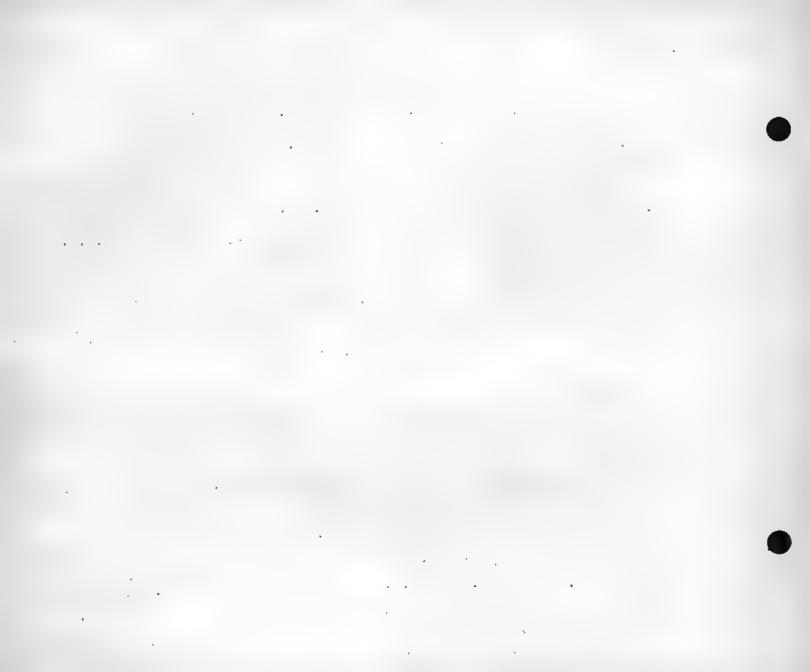
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1_	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
= 401	OSISS CERTIFICATE OF DEATH
hours after death, d in by the funeral rs. Pages 1 and 2 bours after death.	1. PLACE OF DEATH a. CDUNTY AND LL  MARYLAND  2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) b. CDUNTY FARCE 11 (K
urs aft in by th Pages ours aff	b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)  Sykelvice  3yrs. 7m. 22 mys.  Thursaick
fifter in 724	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  - Springfield State Hospital 702-9th Ave.  8. IS RESIDENCE DN A FARM? YES NO 12
l withir npletely carbon nt, wit	3. NAME DF DECEASED (Type or print) Ethet Mary Utlerboack 4. DATE Month Day Year OF DEATH Peprit 16 1966
executed within and completely remove carbon I any event, with	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE DF BIRTH Female White WIDDWED DIVORCED 3-18-87 9. AGE (In years   FUNDER 1 YEAR   IF UNDER 24 HRS.   Iast birthday) Months Days Hours Min.
sician sician and in	10a. USUAL DCCUPATION (Give kind of work done during most of working life, even if retired)  House wife  11. BIRTHPLACE (County & State, or foreign country)  12. CITIZEN OF WHAT CDUNTRY?  13. Girls of working life, even if retired)
rtificate ng phy Then pl moval,	13. FATHER'S NAME  Samuel G. Hurst Tacy Lanham
eath cartificate by attending physician aremit. Then please room, or removal, and in	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY ND. 17. INFORMANT Address (Yes, no, or unkown) (If yes give war or dates of service)  None Hospital necolds.
the d by the osit p	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  Brokehopmenmonia  Cay S
w requires that ending physician as been signed I as the burial-trai rrior to burial, cr.	conditions, it any, which gave rise to immediate (b) Anterio scherotic correir vascular disease years
law requir ttending p has been as the bi	cause (a), stating the DUETD GENERALIZED anteriosclerosis.  years.
te The la tal or att incate h for use Health p	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  PERFORMED?  YES NO   DR CONTRIBUTING CAUSE OF DEATH  OR CONTRIBUTING CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER)  19. WAS AUTOPSY PERFORMED? YES NO   OR CONTRIBUTING CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER)
PHYSICIAN: the hospital this certifi detached fo e Dept. of H	
	2Dc. TIME OF INJURY Month, Day, Year   2Dd. INJURY DCCURRED   2De. PLACE DF INJURY (Home, farm, Hour a.m.   While   Not While   At work   At wor
ENDIN ined l R. Af ould 1	21 Legrify that #0 (this hospital) attended the deceased from 8 - 2 \( \times \) 1962 to 4 - 16 - 1966, that #0 (we) last
OR ATTENDING be retained by JIRECTOR: After ge 3 should be ed with the State	22a. SIGNATURE  22b. DATE SIGNED  ATTENDING MED. STAFF
	220. PHYSICIAN'S NAME (Type) SUHA CZGUN  22d. ADDRESS NAME (Type) SUHA CZGUN  22d. ADDRESS Springfield State Hosp, Sike sville Maryland
TO HOSPITAL Page 4 may TO FUNERAL Elector, pa Should be fil	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county), (State)  REMOVAL (Specify) 4. 17-36  HINSDORG (CITY) 10 P. 17-36
VR A15 (4)	24. FUNERAL DIRECTOR  ADDRESS  25a. REC'D BY REGISTRAR'S SIGNATURE  LANGE TO BE TO B
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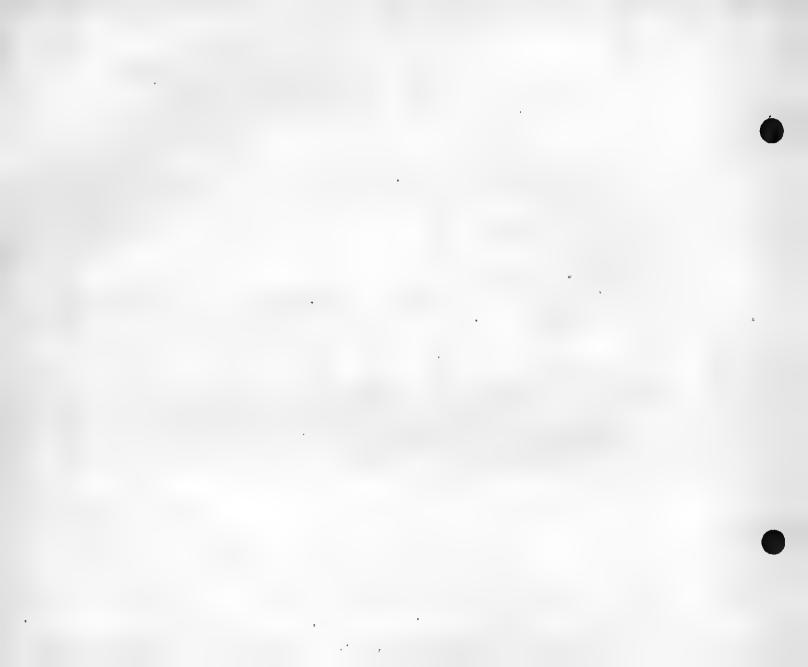


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH a. COUNTY b. COUNTY Carroll Maryland Carroll MARYLAND CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Rural. Westminster Rural. Westminster vears the d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE DN A FARM? 3 to 1 State hours a 82 E. Baltimore Road 82 E. Baltimore YES Road NO OC and 3 NAME OF DATE Middle Last Day Year DECEASED PAUL April 1966 VARNELL DEATH (Type or print) 5. SEX 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED DATE OF BIRTH AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS THE O last birthday) | Months | Days Hours | male whi te WIDOWED [ DIVORCED [ Nov. 21, 1925 1De. USUAL OCCUPATION (Give kind of work done | 10b. KIND DF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (State or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? Merchant Seaman Kansas City, Missouri U.S.A. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME 5 Harvey Varnell Bess Carroll File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no, or unkown) (If yes give war or dates of service) permit. removal. Helen Maverc Varnell same 18. CAUSE OF DEATH [Enter only one ceuse per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND PART I. DEATH WAS CAUSED BY: burial-transit 10 IMMEDIATE CAUSE (a) cremation. DUE TO Conditions, if any, which (b) gave rise to immediate **DUE TO** cause (a), stating the æ used as a to burial, underlying cause last. WAS AUTOPSY PERFORMED? PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) CERTIFICATION NO X YES [ 20a. EXTERNAL CAUSE WAS PRIMARY FOR OF CONTRIBUTING CAUSE OF DEATH. OESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 1) of Item 18.) 3 should bagent, price MEDICAL (County) 2Qc. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e PLACE OF INJURY (Nome, farm.) 20f. (City or lown) (State factory, street, office bldg., etc.) a.m. Not While CTOR: Page designated at work at work should be and in my opinion 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry Fles. Suicide X, death resulted from: Natural causes Accident Homicide Undetermined manner DIRECTO CHIEF MEDICAL EXAMINER YOUR Page ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATUR for DEPUTY MEDICAL EXAMINER N FUNERAL Speicher retained director. NAME (Type) (City, town or county) NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION DATE THEREOF REMOVAL (Specify) Brier Lafayette Hill, Penna. Cemetery 0 remova] Apri REGISTRAR'S SIGNATURE FUNERAL DIRECTOR REC'D BY REGISTRAR 25b. **ADDRESS** VR ALSME (5)

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*		1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
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	eat	and 2 death.	1.	PLACE OF DEATH	1			ii.	2. USUAL RESIDEN	ICE (Where decea	sed lived, If Institution:	Residence I	nefore admission)
	hours after death	e fu		a. COUNTY CARROL	Ē.		MARYLAI	10	MARYLAI	1D	CARROLL		
	aff	by the Pages 1 urs after		b. CITY OR TOWN	N (If outside corporation and give nearest tow	e limits,	c. LENGTH OF STAY IN		c. CITY OR TOWN (	f outside corpo	rate limits, write RURA	L and give	nearest town)
	ours	in bound		HAMPSTI	EAD	,	hospital, give street add		HAMPSTI			4	. 1
		filled papers in 72 i		d. NAME OF HOS	SPITAL OR INSTITUTIO	N (if not in	hospital, give street add	ess)	d. STREET ADDRESS			6.	IS RESIDENCE ON A FARM?
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	executed within	and completely filled in by the 1 emove carbon papers. Pages 1 fam event, within 72 hours after	3.	NAME DF DECEASED		rst —	Middle		Last	4. DATE	Month	Oay	Year
	, pa	omp ca vent	5.	(Type or print)	GEORG: 6. COLOR OR RACE	7. MARRIEI	Z.	1 4	HEAT DATE OF BIRTH	DEATH	GE (In years LIE LINDE	R 1 YFAR III	1966 FUNDER 24 HRS
	cut	and co		le	White	WIDOWER				2.1900	GE (In years IF UNDE ast birthday) Months	Days	Hours   Min.
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	þe	sicia ease and	dur	ng most of work! Carper	ing life, even if retire hter	d)	INDUSTRY		Marylar	nd		USA	
	cate	physician and please reval, and jir	13.	FATHER'S NAM					14. MOTHER'S MA		<u> </u>		
	ıtil	The		John V					Susan	Baker			
	Š	attending ph ermit. Then m, or removal	15. (Ye:	WAS OECEASED (	EVER IN U.S. ARMED FO (If yes give war or dates o	f sourcien \	SOCIAL SECURITY NO.		NFORMANT		Address	3 37	
	Jeat	e at con,	_	no		12.	14-03-7099	MI	rs. Rober	t Utz,	Hampstea		
	that the death certificate be sician.	training projects has been signed by the attending phy as the burial-transit permit. Then ply prior to burial, cremation, or removal,			DEATH [Enter only on ATH WAS CAUSED BY	- 1	Une for (a), (b), and (c).]	1.	0 1	1. 1		INTER	VAL BETWEEN T AND DEATH
	iat t	tran cre	Н	./ ^	IMMEDIATE CAUSE	(a)	ujoinu	ca.	1 100	faren	M.	-	
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	requires	6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6		gave rise to	Immediate	(b)		-					
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	PHYSICIAN:	this certificate detached for use					INTURY DOCUMENTS LOS	Disor	OF INTERNATION	farm 1 006 (0)	the of bound	ounty)	(State)
		te Det The	MEDICAL	Hour a.n	INJURY Month, Day, n.	While		factory,	OF INJURY (Home, , street, office bldg.,	etc.)	ty or town) (C	Outrey)	(2tato)
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	ATTENDI	DR:	П		y that (I) (this hos ceased alive on 2	atten	ded the deceased from		death occurred at	19 /4 , to /2	the causes and on		t (I) (we) last
	TA to	With W		22a. SIGNATUR			1522, 410	tildt v			22b.	DATE SIGN	VED
	- 08 dd	DIR Jed	Н	14-1	4. Vic	ucyle	\$	M.D.	ATTENOING PHYS.	MED.	STAFF PHYS.		
	TAI	RAL De f		22c. PHYSICIA NAME (T)	in's /pe)	0			22d. ADDRESS				
	HOSPITAL Page 4 may	To FUNERAL DIRECTOR: After director, page 3 should be should be filed with the State	23a	Pliplat open	INTION 1 925 DATE	FNEDEOE	29c. NAME OF CEM	TEPY A	DD CDEMATORY	1 234 100	ATION (City, town or o	ounts)	(State)
	10	dir.	23a	REMOVAL (Spe	ocify) 1. /3 1. /	L /							Ma
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH death. funera and a death. PLACE DF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY Carrell Marvland by the Pages 1 Carrell MARYLAND b. CITY OR IDWN (if outside corporate limits, C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) filled in by papers. Pag in 72 hours write RURAL and give nearest town) 8 Yrs. Sykesville RD#4 Sykesville RD#4 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Near Sykesville Near Sykesville Ba ND X YES within d 3. NAME DE DECEASED Middle Last DATE Day Month e carb 3 Year ANIEL WHIPP (Type or print) April 20. DEATH 19 66 executed 6. COLDR OR RACE 7. MARRIED C NEVER MARRIED SEX DATE OF BIRTH AGE (in years | IF UNDER 1 YEAR | IF UNDER 24 HRS. rem n an last birthday) Months White Male Days Hours 1 March 1884 WIDOWED DIVORCED [ 1Da. USUAL DCCUPATION (Give kind of work done) .5 10b. KIND DF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) been signed by the attending physician the burial-transit permit. Then please of the burial, cremation, or removal, and in 12. CITIZEN OF WHAT þ Retired—Farmer Farm Owner **COUNTRY?** Adamstewn, Md. U.S. death certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Maria Shellman John N. Whipp 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY ND. I 17. INFORMANT Address (Yes, no, or unkown) I (If yes give war or dates of service) Ne 219-36-2620 Mrs. Dera S. Whipp (Same as item #1) CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY: PHYSICIAN: The law requires that the fospital or attending physician. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate DUE TD 4-20-66 cause (a), stating the underlying cause last. has as pric (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) certificate hither than the state of Health p WAS AUTOPSY PERFORMED? ND X YES 2Da. ACCIDENT WAS UNDERLYING I DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part 1 or Part 1) of Item 18.) is certi tached factor OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) de factory, street, office bidg., etc.) Hour a.m. After While Not While at work ATTENDING p.m. O HOSPITAL OR ATTENDI Page 4 may be retained should ith the S TO FUNERAL DIRECTOR: A director, page 3 should should be filed with the 21. I certify that (I) (this hospital) attended the deceased from that (I) (we) last and that death occurred a saw the deceased alive on M, from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED page ATTENDING MED. DIRECTOR STAFF 20 April 1966 M.D. HOSPITAL PHYSICIAN'S 22d. ADDRESS NAME (Type) 23a. BURIAL, CREMATION, DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) REMOVAL (Specify) -23-66 Mount Olivet Cemetery Frederick, Md. 21701 24. FUNERAL DIRECTOR REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE Etchisen Sem. Frederic VR ALS (4) 2DM 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH death. funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY 24 hours after n and completely filled in by the it remove carbon papers. Pages 1 in any event, within 72 hours after Carroll Maryland Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b write RURAL and give nearest town) 14 years Finksburg RD #2 Finksburg RD #2 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Box 410 NO N YES ithin 3. NAME OF DECEASED First Middle 4. DATE Last Month Year 28 1966 (Type or print) JAMES WHITE DEATH April 5. SEX 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED AGE (in years | IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) | Months | Days | Hours | Min. DATE OF BIRTH male white March 17.1917 WIDOWED [ DIVORCED 40 10e, USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) physician an please rays, and in 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or fereign country) certificate be COUNTRY? U.S.A. Nat'l Dairies auto mechanic Jeannette. Pa. removal, 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME O FUNERAL DIRECTOR: After this certificate has been signed by the attending pt director, page 3 should be detached for use as the burial-transit permit. Then should be filed with the State Dept. of Health prior to burial, cremation, or remova William White Nora McCarthy 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address OR ATTENDING PHYSICIAN: The law requires that the death be retained by the hospital or attending physician. (Yes, no, or unkown) (If yes give war or dates of service) 209-09-3388 Mrs. Beatrice V. White Бате INTERVAL BETWEEN ONSET AND DEATH 5 min. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Coronary Occlusion IMMEDIATE CAUSE (a) DUE TO Angina Pectoris 2 hrs. Conditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating the underlying cause last. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NO X YES 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF BEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 1) of Item 18.) MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) (County) (State) Hour a.m. While Not While at work at work to 4-28-66 21. I certify that (I) (the Kaskel) attended the deceased from 1-7-55 19. 19 saw the deceased alive on Apr. 28 .19.66 and that death occurred at 9. A.M. from the causes and on the date stated above. 22b. DATE SIGNED 228. SIGNATURE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 4-28-66 Page 4 may ! M.D. **ADDRESS** PHYSICIAN'S 22d. NAME (Type) Caples, M. D. D. 6 Hanover Rd., Reisterstown, Md. 23a. BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) 2 5/2/66 Evergreen Memorial Finksburg, Md burial Gardens FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE VR A15 (4) 15M 4-64

1 L		DIVISION	OF STATISTIC	MAR AL RESE	RYLAND ST FARCH AND	RECORDS	PARTMENT OI , 301 W. PRESTO	F HEALTI	H F RALTIM	OPE 1 MAI	DVIAND	
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hours after death.  d in by the funeral rs. Pages. 1 and 2 thours after death.	1.	PLACE DF DEATH a. COUNTY					a STATE		ased lived, If I	JNTY	dence before admissi	on
by the pages 1	<b>!</b>	b. CITY OR TOWN	(if outside corporate nd give nearest town	limits,	c. LENGTH OF	MARYLAND STAY IN 1b	c. CITY OR TOWN (I	land Foutside corp	orate limits, v	Howard vrite RURAL en	d give nearest to	MN
nours a		Sykesyi	lle		3 mos	s. 26 d	rs. Sav	age			1	
24 hour filled in 72 hour in 72 hour			ITAL OR INSTITUTION		hospital, give st	eet eddress)	d. STREET ADDRESS				e. IS RESIDEN	ICI I?
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rted within completely ve carbon event, with	J.	DECEASED (Type or print)		RLES		LIAM	WHITEHEAD	DF DEATH		oril	20 19 66	4
ite be executed within 24 hystoric and completely filled please remove carbon paper, and in any event, within 72	5.	SEX	6. COLOR OR RACE	7. MARRIEI	NEVER MA		B. DATE OF BIRTH	9.	AGE (In year)	S IF UNDER 1 Y	EAR IF UNDER 24 H	IR!
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The law requires that the death certificate or attending physician. Sate has been signed by the attending physics as the burial-transit permit. Then ple salth prior to burial, cremation, or removal, salth			TH WAS CALIFED DV.	_			OF LEFT TOASIL	WITH KEE	K METAS		ONSET AND DEAT	Ή
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OK ATTENDING PHYSICIAN: The law requires that the death be retained by the hospital or attending physician. IRECTOR. After this certificate has been signed by the at g 3 should be detached for use as the burial-transit permed with the State Dept. of Health prior to burial, cremation,	CERTIFICATION	OR CONTRIBUTIN	'AS UNDERLYING [] G [] CAUSE OF DEAT FY MEDICAL EXAMIN	H ER)	DESCRIBE HOW	INDUKT OCCU	RRED. (Enter nature o	i injury in Pe	nt I Or Part II	or item 10.)		
ING PHYSICIAL d by the hospi After this cert i be detached State Dept. of	MIDICAL		JURY Month, Day, Y			Fanto	CE OF INJURY (Home, f ry, street, office bldg.,	arm, 2D1. (	Olty or town)	(County	y) (State	)
<b>在</b>	M	Hour a.m. p.m.	19	While at wo	Not While rk at work		Type ( oot, onloop tage,					
TTENDI trained TOR: A should th the			that (I) (this hospi	ital) attend -20-66			12-24-55	2:20:19	4-20-6		., that (I) (we) I date stated abo	
ATT retz 3 sh with		22a. SIGNATURE	1000	/	1/_/9	and that	death occurred at	M,-Tro		22b. DATI		JVe
DIR DIR			i can	0 (1	, com	7 _ м.г		MED. DIRECTOR	STAFF PHYS.			
TO HOSPITAL OK ATTENDIN Page 4 may be retained TO FUNERAL DIRECTOR. At Mirector, page 3 should is should be filed with the S		22c. PHYSICIAN NAME (Typ	Octavio A	Ruiz	M.D.			Springf Sykesvi		ate Hos	pital 21784	_
D HOSPI Page 4 D FUNER Trector Should b	23	BURIAL, CREMA	TION. 23b. DATE T	HEREOF		OF CEMETERY	OR CREMATORY			town or count	(State)	
	2	FUNERAL DIREC	TOR 1	.061	ADDRES	s y	(Cm) 25e. RE	C'B BY REGIS	TRAR 1 250.	RECISTRAR'S	SIGNATHRE	
VR A15 (4)	R	1.11911	Assembly de	11 11	le deli OF	MA AN	DATE	APR 29	1966	Julian	ces judge	-
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH 05163 05164 requires that the death certificate be executed within 24 haurs after death nd completely filled in by the funeral temove carban papers. Pages 1 and any event, within 72 hours after degs PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Carroll Maryland Allegany MARYIAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 days Riral--Sykesville Cresaptown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital NO VI Middle 3. NAME OF 4. DATE Lost Doy Year DECEASED OF 19 66 Belle (Type or print) Marv Zarger DEATH S. SEX 6 COLOR OR RACE B. DATE OF BIRTH IF UNDER 1 YEAR AGE (In years 7. MARRIED NEVER MARRIED birthdoy) Months Doys Hours 6/10/86 white WIDOWED DIVORCED T female 11. BIRTHPLACE (County & Stote, or foreign country) 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life even if retired) COUNTRY? Maryland-Artemas, Pa USA 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Eliza Leasere Simon Clingerman 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT signed by the attendir burial-transit permit. (Yes, no, or unknown) (If yes give wor or dates of service) 9 unknown Springfield Hospital records -- Sykesville INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) Cardiac failure due to myocardial infarction days PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (6) DUE TO Conditions, if ony, which gove Arteriosclerotic cardiovascular disease years rise to immediate couse (o), DUE TO Page 4 may be retained by the haspital or attending O FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached far use as the should be filed with the State Dept. of Health priar tall stoting the underlying couse Chronic bronchitis years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? Chronic brain syndrome associated with senile brain disease with psychotic reaction.

20b. ACCIDENT WAS UNDERLYING | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I of item IB.) YES . NO OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Heur o.m. Not While foctory, street, office bidg., etc.) 19 of work nt work 4/17/ , 1966, that (# (we) last 1966_, to. 21. I certify that the (this haspital) attended the deceased from 19 66, and that death accurred at 11.30 M, fram causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 22o. SIGNATURE ATTENDING MED. DIRECTOR 4/17/66 CAMPAGE ARE M.D. PHYS. PHYS. Springfield State Hospital 22c PHYSICIAN'S 22d. ADDRESS NAME (Type) Maneeratana Fuangvudhiran. M.D Sykesville. Maryland 230. BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) April 21,1966 Hillcrest Burial Park Cumberland, Ma. 0 BET RESISTRATO 256 PRESISTRAT'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 James F. Scarpelli, Cumberland, Ma.

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1 3/	DIVISION OF STATISTICAL RESEARCH	ID STATE DEPARTMENT OF HEALTH AND RECORDS, 301 W. PRESTON STREET, B	ALTIMORE 1, MARYLAND
E 50	C 100 1 1/2 100	ERTIFICATE OF DEATH	05164
er death.	1. PLACE OF DEATH 2. COUNTY CARROLL	2. USUAL RESIDENCE (Where deceased a. STATE	lived, If institution: Residence before admission) b. COUNTY CARROII
24 hours after death filled in by the funeral apers. Pages 1 and a n 72 hours after death	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  RURA SYRESVILLE  d. NAME OF HOSPITAL OR INSTITUTION (if not In hospital,	MONTH & SUKESIVITE	a limits, write RURAL and give nearest town)
	Linger Nursing Home	Springfield A	9 Ve , SRESIDENCE ON A FARM? YES NO X
uted w comple	(Type or print) Frederick W.	Middle Last 4. DATE OF DEATH A VER MARRIED 8. DATE OF BIRTH 9. AGE last	Month Day Year  Dri 25 19 66  An years   FUNDER 1 YEAR   FUNDER 24 HRS. birthday)   Months   Days   Hours   Min.
	10a. USUAL OCCUPATION (Give kind of work done industry most of working life, even if retired)  10b. KIND OF INDUSTRY  FARMER	BUSINESS OR 11. BIRTHPLACE (County & State, or for	yrs.
ding Ther Ther	ZA CHARY ZIMMERMAN	Annie C. L	BAER
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, for unknown) (If yes give war or dates of service)  18. CAUSE DF DEATH [Enter only one cause per line form		RMAN - Sykesville, M.
requires that the ding physician. been signed by the burial-transion to burial, crem	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO Conditions, If eny, which gave rise to immediate cause (a), stating the  DUE TO  DUE TO  ORS	wender Edema Lecular Silvilation	onset And Death Classes  Classes  10 egrs.
The late or at cate he cate he ealth	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO  OR CONTRIBUTING CAUSE OF DEATH  OR CONTRIBUTING CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER)	ion. Generalized 4.	PERFORMED? YES NO W
T- 00	20c. TIME OF INJURY Month, Day, Year   20d. INJURY ( Hour a.m.   While - No	CCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, offica bldg., etc.)	or town) (County) (State)
OR ATTENDING DE retained by INECTOR: After 3 should be ed with the State	21. I certify that (I) (this hospital) attended the saw the deceased alive on 25	deceased from JAN 26 , 1983, to #1996, and that death occurred at Jan, from the	1966, that (I) (we) last the causes and on the date stated above.
	22c. PHYSICIAN'S NAME (Type) Sami Okufu	MAN. ATTENDING MED. SPHYS. DIRECTOR PHYS.	TAFF 4.26,1966
TO HOSPITAL Page 4 may TO FUNERAL director, pa	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. BUCKA (Specify) 4-28-66	NAME OF CEMETERY OR CREMATORY 23d. LOCATION SYK	ON (City, town or county) (State) esville, Me.
VR AIS (4)		ADDRESS  DATE  DATE	25b REGISTRAR'S SIGNATURE

A STATE OF THE STA Marie Control Company of W. Armster ASSESSED AND SECOND A THE WAR DE COMMENT OF THE PARTY OF THE PAR STOKEN OF THE WILLIAM STOKEN